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ABSTRACT

Substance abuse continues to be one of the most damaging and chronic health problems faced by Indian people. American Indian and Alaska Native (AI/AN) substance abuse prevention and treatment programs must be framed within the broader context of the widening health disparities between AI/AN communities and the general population. Successful treatment and prevention of health problems, including substance abuse, must be driven by community needs and blend complementary strategies from Western medicine and traditional healing practices. This collection of works by substance abuse experts and public health researchers explores, within a public health framework, the multiple dimensions of AI/AN substance abuse treatment and prevention from an AI/AN community perspective. Chapters are: (1) "Prevention of Alcoholism, Drug Abuse, and Health Problems among American Indians and Alaska Natives: An Introduction and Overview" (Joseph E. Trimble, Fred Beauvais); (2) "Prevention Principles for American Indian Communities" (James R. Moran); (3) "Worldview, Identity, and Prevention in American Indian Communities" (Grace Powless Sage); (4) "Prevention in Alaska: Issues and Innovations" (Gerald Mohatt, Kelly L. Hazel, Jűstin W. Mohatt); (5) "Using the Community Readiness Model in Native Communities" (Pamela Jumper-Thurman, Barbara A. Plested, Ruth W. Edwards, Heather M. Helm, Eugene R. Oetting); (6) "Native American Perceptions of the National Association for Native American Children of Alcoholics: In Their Own Words" (Jeannette L. Johnson, Bradford W. Plemons, Edward Starr, Raymond Reyes, Candace Fleming, Anna Latimer, Joseph E. Trimble); and (7) "Do School-Based Drug and Alcohol Abuse Prevention Programs Work in American Indian Communities?" (Fred Beauvais). (Contains references in each chapter.) (TD)

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Cultural Competence Series

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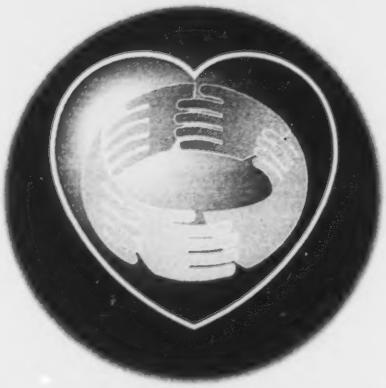

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence

ED 452 003

CSAP Center for Substance Abuse Prevention
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Substance Abuse and Mental Health Services Administration
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Special Collaborative Edition

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence

Special Collaborative Monograph produced in conjunction with:
The Bureau of Primary Health Care, Health Resources and Services Administration
The Office of Minority Health, Department of Health and Human Services
The Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

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Foreword

The ninth volume of the collaborative cultural competence monograph series, *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence,* provides another opportunity for the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention, the Health Resources and Services Administration's Bureau of Primary Health Care, and the Office of Minority Health of the Department of Health and Human Services to collaborate in this unique series on cultural competence. This volume is part of a series of "reoriented" cultural competence publications that expand the original substance abuse focus of these volumes to include broader health services–oriented topics inclusive of substance abuse concerns. The health services fields of minority health and primary health care now join this series in an unprecedented collaborative volume that views health care, prevention, intervention, and treatment as integral to the health status of ethnic, racial, and cultural populations. This volume explores questions of concern to health services, to primary care and substance abuse practitioners, and to evaluators wishing to enhance their abilities in working with the diversity of populations that embody the term *American Indian and Alaska Native.* This volume is intended for a broad audience of students, practitioners, clinicians, evaluators, and researchers wishing to broaden their expertise in the crucial issues that bridge culture and health within Native American populations. The topics contained in this volume are pivotal to the growing interest of the managed care industry in their attempts to foster positive health outcomes, to improve accessibility to services, and to increase quality of covered lives and consumer satisfaction.

This Cultural Competence Series has as its primary goal the scientific advancement of evaluation and practice methodology designed specifically for health services, primary health care, and substance abuse prevention approaches within the multicultural context of community settings. The various multicultural communities that make up our country comprise a rich

and diverse ethnic heritage. The Cultural Competence Series is dedicated to exploring and understanding this heritage and its critically important role in the development of culturally and linguistically accessible health services and substance abuse prevention programs.

The Cultural Competence Series provides the public health and substance abuse prevention fields with a unique opportunity to formulate effective strategies that will have applicability for professionals working in widely diverse settings. This unprecedented Series has established a framework for the transfer of innovative, cutting-edge technology in this area and a forum for the exchange of knowledge among program developers, implementers, and evaluators. It is the sincere hope of those who have contributed to this Series that it will stimulate new ideas and further prevention efforts among all Americans.

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Preface

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Through a collaborative effort by renowned substance abuse experts and public health researchers, this monograph explores, within a public health framework, the multiple dimensions of American Indian and Alaska Native (AI/AN) substance abuse treatment and prevention from an AI/AN community perspective. Despite the establishment of a legal foundation for the public provisions of Indian health services that began in the early 19th century, a positive health status for AIs/ANs has not yet been secured. Substance abuse continues to be one of the most damaging and chronic health problems faced by Indian people. Identifying and developing appropriate AI/AN substance abuse prevention and treatment programs must be framed within the broader context of the health disparities that have impacted health status and health care delivery systems in AI/AN communities (reservation, rural, and urban). Although AIs/ANs represent 1 percent of the U.S. population, health disparities between American Indians and the general population continue to widen at an alarming rate. For example, morbidity and mortality rates for AIs/ANs are consistently higher than the general population (Indian Health Service, 1998).

These health problems and continued health disparities tear at the fabric of AI/AN communities, producing devastating consequences. To eliminate AI/AN health disparities, any meaningful health care services and/or health policy reform must be driven by the needs of the community. To best identify these needs, comprehensive AI/AN health data must be available. However, very little AI/AN health data are collected and research has rarely addressed the role of culture in healing processes. We are hopeful that the work to be carried out through the national *Healthy People 2010* objectives will address this need for better data.

Traditional AI/AN healing systems focus on balancing mind, body, and spirit within the community context. In 1994,

the SAMHSA, through its Center for Substance Abuse Treatment, funded a national, 5-year demonstration grant to examine the role of traditional healing practices. The establishment of an AI/AN "Cultural Committee," composed of traditional healers, marked one of the first HHS efforts to include traditional practices within the continuum of substance abuse care for Indian people. We are hopeful that more programs emphasizing traditional AI/AN healers collaborating with conventional Western public health approaches will continue.

Because 21st century Indians are bicultural, successful treatment and prevention for health problems, including substance abuse, need to blend complementary strategies from Western and traditional healing practices. Additionally, the inherent strengths and resilience of Indian people and their communities must be incorporated into the treatment-prevention process if sustained and successful healing interventions are to occur. The 21st century approach to eliminating the AI/AN substance abuse problem must respect traditional healing practices that aim to restore the balance and harmony to the mind, body, spirit, and community. Only then can the health disparity gaps be eliminated. This publication is one step of many needed to address the substance abuse problem, eliminate health disparities, and improve the health, well-being, and quality of life of every American Indian and Alaska Native person living within the United States—*our* historic and traditional lands.

Walk in peace and harmony.

Reference

Indian Health Service. (1998). *Trends in Indian Health*. Rockville, MD: U.S. Department of Health and Human Services.

1

Prevention of Alcoholism, Drug Abuse, and Health Problems Among American Indians and Alaska Natives: An Introduction and Overview*

Joseph E. Trimble
Fred Beauvais

I grew up with it. Everyone drank where I grew up. Everyone did. You know, kids, and the adults, and, I guess growing up that was just the way to go. There wasn't any other way. It was like you can't wait to be 21 so I can go into bars legally even though I was already in them. That was just a way of life. When we sobered up, it's still like you kind of don't fit in. It's really difficult, humiliating almost. It's almost easier to go along with the flow than to sober up.

—Anonymous American Indian informant (1995)

* This chapter was supported in part by funds provided by the National Institute on Drug Abuse (Grant Numbers DA03371 and DA07074).

These compelling and profoundly moving words reflect the thoughts and sentiments of countless American Indians and Alaska Natives. Indeed, alcohol misuse is considered by most of America's indigenous population to be their most serious and significant health problem, a problem that affects almost every facet of life. Discussions about mental and physical health, deviance, familial problems, and community structure and function among American Indians must include, in some form or another, the influences of alcohol use and misuse. Yet it is extremely bold to assume that if the widespread use and misuse of alcohol was significantly reduced in American Indian communities that the prevalence of health and psychosocial problems would be eliminated; historical events have led to many structural problems that create numerous stressors in these communities. It is reasonable to conclude, though, that culturally resonant alcohol and drug use prevention strategies, if effective, would contribute to the reduction of illness, disease, deviance, and community disruption. Further, any discussion of alcohol problems in American Indian communities, grave as they are, must recognize that there are many American Indian people for whom alcohol poses little or no personal problems. Stereotyping of all American Indian people should clearly be avoided.

This monograph presents an inquiry into the prevention of alcohol and drug use in American Indian and Alaska Native communities. Our inquiry into the broad-based topic of prevention as a tool for health promotion and maintenance is restricted to substance use and misuse in large part because it is the area in which most of the research and development has occurred, due to its high incidence and prevalence among American Indians and Alaska Natives. To place our inquiry in perspective, this introductory section will provide an overview of substance use and misuse among American Indians and Alaska Natives and as a consequence serve as background for the other chapters contained in this monograph. To set the inquiry in motion, the first section provides important information on the demographic characteristics of America's indigenous people. The second moves to an overview of the substance use and misuse field.

Demographic Characteristics of American Indians and Alaska Natives

The terms *American Indian* and *Alaska Native* are "ethnic glosses" (Trimble, 1991, 1995). They refer to the aboriginal populations of North America and are terms imbued with political and sociocultural considerations. In this chapter, *American Indian* and *Indian* are typically used for the sake of brevity and are not meant to demean the distinct heterogeneity that exists among the many native tribes and villages and those who prefer to identify with these entities rather than with the broad glosses. The terms race and racial should be avoided where possible because they do not have relevance for American Indians and Alaska Natives. These concepts are "academic anachronisms" and have little scientific and practical value, in part because of their elusive, unbounded nature (see Yee, Fairchild, Weizmann, & Wyatt, 1993).

The term *American Indian* is an imposed, invented ethnic category originally foisted on the Arawak, a now-extinct Caribbean-basin tribe. The category continues to be used to the extent that almost all indigenous native peoples of the Western Hemisphere are referred to as Indians. Many pejorative, historical, and stereotypical images are incorporated in the meaning when it is used by outgroup members, but contemporary American Indians have also found some value in self-identification with this broad gloss. Speaking to this point, Trosper (1981) cogently argues that "American Indians have transformed themselves from a diverse people with little common identity into an ethnic group" and that they "have done so by mobilizing, with respect to a charter, the shared history of broken treaties" (p. 257). By forging a common ethnic category, America's indigenous population has created a social and political force that has far greater strength and influence than do individual tribal governments; the emergence of the pan-Indian category has created a conventional label with which one can identify (see Hartzberg, 1971).

Tribal-Specific Definitions

Tribal groups had names for themselves and, indeed, linguistic-specific names for other tribal groups. Within their own languages, the names of tribes such as Lakota, Cheyenne, Navajo (Diné), and Hopi mean "human beings" or "the people." Within tribes, bands such as "those with burned thighs" or "those who plant near the water" and moieties such as "Eagle" or "Raven" were given specific names that refer to some idiosyncratic or spiritual characteristic. In addition, tribes such as the Lakota referred to other tribes according to stereotyped physical features and characteristics: the Cheyenne were referred to as *Sihiyena* (people with a shrill voice), the Winnebago as *Hotanke* (loud-voice people), and the Navajo as *Sna-hde-hde-hi* (those with striped blankets). Such distinctions were typically ignored by American colonialists, historians, and novelists, leaving the world with the erroneous impression that American Indians were a distinctive but singular lot.

Government Attempts at a Definition

The Federal Government, through the Bureau of Indian Affairs (BIA), found it necessary to provide a legal definition of an American Indian, the only ethnic group in the United States afforded this distinction. The definition has undergone numerous revisions in the past 100 years or so, but currently the BIA defines an American Indian as a person whose American Indian blood quantum is at least one-fourth, and/or who is a registered or enrolled member of one of the 557 federally recognized tribes. The hard-and-fast criteria of BIA eliminated many people of American Indian background who affiliated in one form or another with one of some 60 federally nonrecognized tribes, ones that in many cases never signed formal treaties with the Government or that were part of scattered, small groups in the Northwest and the Southwest (see Snipp, 1989, 1996).

Some recognized, or "treaty," tribes do not agree with the BIA criteria and have developed their own specifications. Some have lowered the blood quantum criterion to one-eighth and

even one-twenty-eighth and a few have increased it to one-half. One tribe in Oklahoma in the late 1960s opened its rolls to anyone who could prove ancestral ties; the specific blood quantum was not viewed as an important criterion. About 7 percent of the tribes require that one have more than one-fourth blood quantum and about 32 percent have no set blood quantum criteria. Whatever the criteria, individuals must be able to establish their claim by providing documentation showing that one or more of their relatives or ancestors are on some version of a tribe's roll or census (Thornton, 1996).

The United States Census Bureau and the Department of Education (DOE) each developed their own criteria. The Census Bureau allows each citizen to declare his or her ethnic origin on the basis of the group with which he or she most identifies—in a word, the criterion is self-enumerative. After conducting an extensive survey among American Indian people throughout the United States, DOE staff generated some 70 distinct definitions of "American Indian." After a careful review of the results, DOE decided on a definition that closely resembles BIA criteria but provides more latitude for tribal-specific criteria, regardless of Federal status (U.S. Department of Education, 1982).

Government definitions are developed largely to determine who is eligible for services provided by treaty arrangements and congressionally mandated programs. The definitions do not include the extent to which an individual follows tribal custom and tradition or the degree to which he or she professes an ethnic identification.

Interaction and Validation Styles

Among most American Indians, merely being federally recognized and fitting the definitional criteria of the BIA and DOE are not sufficient. For many, it is vitally important to glean a sense of the way someone lives and subscribes to traditional and readily identifiable lifestyle patterns. As a consequence, when two strangers meet and it is apparent that both possess distinctive physical characteristics—dark, straight hair; dark brown eyes; brown skin; high cheekbones; broad nasal struc-

ture; and other distinguishing features—they seek to elicit information from each other to substantiate degree of ethnic affiliation. Using a nesting procedure, one will ask questions—"Where are you from?" "What tribe do you belong to?" "Who are you related to?"—in an effort to generate some commonly shared background. If one or the other doesn't quite fit the physical stereotype, the conversation may well turn to identifying which parent or grandparent was not American Indian and what the person's blood quantum might be. This is usually a delicate subject, so it is often handled rather carefully. If all of the information appears authentic and genuine, the conversation may lapse into one in which each shares stories about presumed common life experiences. Often the conversation takes on a form of "homeland centrism," in which the daily, contemporary lifestyle of the individual's origins is emphasized over tribal customs and traditions. Hence, American Indians from reservations are likely to discuss socializing influences more indicative of contemporary lifeways back home than to give attention to classic tribal customs. In a very subtle way the conversation is designed to provide evidence not only that the participants are American Indians by definition, but also that they have the experiences to back that up—experiences that demonstrate the authenticity and strength of the identification with one's ethnic origins.

Demographic Patterns

The Census Bureau currently uses a self-identification procedure to establish American Indian identity. Their definition is a departure from those developed by tribes, States, and the BIA, as no one is necessarily required to document their claim. The Census Bureau data therefore are at odds with the data maintained by the BIA and data monitored by State agencies. In 1990, the Census Bureau declared that 1,959,000 citizens were American Indians or Alaska Natives. In 1960, the Census Bureau noted that 552,000 reported they were American Indian. Thus, between 1960 and 1990 the American Indian population had grown by about 255 percent. The rapid 30-year population

increase is somewhat incredible—such population increases are almost unheard of in the field of demography. This suggests that many more citizens chose to identify with their American Indian heritage in 1990 than in 1960.

The Census Bureau's use of a self-identification criterion indeed had some effect on growth as individuals likely declared an ancestral identification without having legal ties to a tribe. Some of these individuals are those who claim multiple tribal backgrounds, yet their blood quantum for any one of them is insufficient for them to become officially registered or enrolled. For example, such individuals may have a combined American Indian blood quantum of one-half but no one tribal quantum is acceptable by each of the tribes represented in their ancestral background; they may have all of the facial features demonstrative of American Indians (that is, they look "Indian") but are not qualified to be recognized by either State- or federally recognized tribes.

Many Americans of American Indian mixed ethnic ancestry choose to identify as American Indian or Alaska Native because it creates a new identity for them that brings with it pride along with the desire to learn tribal customs, traditions, and language. Additionally, there are some people who, regardless of their degree of blood quantum, are obligated by family traditions to continue their identities as American Indian or Alaska Native. Typically, they are descended through matrilineal or patrilineal lines that are part of a highly complex clan or moiety system. To sever the ties by refusing to identify or ignoring their ancestry often brings about banishment from the clan and hence the tribe, often casting a shadow of foreboding on the entire extended family.

In 1990, slightly over half of the American Indian population resided in urban areas. The demographer Matthew Snipp maintains that "roughly half of the all urban American Indians can be found in as few as 16 cities, including Tulsa, Oklahoma City, Los Angeles-Long Beach, Phoenix, Seattle-Tacoma, Riverside-San Bernardino, New York City, and Minneapolis-St. Paul" (1996, p. 38). According to the sociologist Russell Thornton, urban American Indians are less likely to speak or understand their

tribal language, participate in tribal cultural activities, report tribal affiliation, or marry American Indians than those who reside in rural communities, villages, or reservation communities. "If these trends continue," Thornton argues, "both the genetic and tribal distinctiveness of the total Native American population will be greatly lessened" (Thornton, 1996, p. 110). He adds that "urbanization is likely not only to result in increased intermarriage as more and more Native Americans come in contact with non-Native peoples, but also to diminish further the identity of Native Americans as distinctive tribal peoples tied to specific geographical areas" (p. 111).

In identifying American Indian and Alaska Native samples for behavioral and social science research, researchers often rely on the generic labels to describe and differentiate their respondent groups. In so doing they assume that their respondents share a common, modal understanding of their tribal lifeways and thoughtways; it is as though the researcher believes that all American Indians and Alaska Natives share commonly held, culturally unique mannerisms, styles, and states. In fact, researchers who solely rely on an ethnic gloss to describe American Indians and Alaska Natives actually ignore the richness of cultural variations within these groups and the numerous subgroups that are characterized by distinct lifeways and thoughtways (Trimble, 1991).

Use of broad ethnic glosses to describe any ethnic group in a research venture is poor science. Apart from the fact that glosses are gross misrepresentations, their use violates certain tenets concerning external validity and indeed fosters stereotypes. Heath (1978) argues that "categories of people such as those compared under the rubric of 'ethnic groups' are often not really meaningful units in any sociocultural sense" (p. 60). He goes on to add, "it is...little wonder that epidemiological and other data collected under such rubrics (i.e., ethnic minorities and other nationalistic groups) are virtually meaningless" (p. 60).

At an individual level one may rely on labels to describe their ethnic affiliation and subsequently their identity. Use of the label, though, is a small part of the identity process, as

one is likely to expand the labeling to include other subjective identifiers such as natal background, acculturative status, ego-involvement, and attitudes toward own and other groups; behavioral preferences such as language usage, friendship affiliations, music and food preferences, and participation in cultural and religious activities may also be included (Trimble, 1991). Hence, any research involving American Indians and Alaska Natives must take into consideration these factors and those discussed earlier to account for the depth of one's identity.

Overview of Substance Abuse Prevention Among American Indians and Alaska Natives

In 1982, the American Indian anthropologist Spero Manson edited the first known book devoted exclusively to the subject of prevention among American Indians and Alaska Natives. The book's contents covered five sections that included research, training, services, evaluation, and recommendations. This seminal work set an important and significant tone for a field that at that time had received little or no attention. Manson (1982) pointed out in his opening chapter that "relatively little prevention research has been conducted in the area of American Indian mental health. Much of that which exists represents a very narrow focus" (p. 11). Considerable prevention research has occurred since his work was published. Yet the published works have largely focused on the substance abuse field and in many instances deal with commentary and recommendations rather than with the research on prevention. Indeed, many important and relevant etiological and epidemiological studies exist documenting over time the prevalence and use rates of alcohol and drugs. The findings are compelling and continue to point to the need for more prevention-specific research, a point echoed more than 18 years ago by Manson and his colleagues. What follows is a detailed summary of these findings.

Setting

The characterization of the physical, sociopolitical, and economic conditions affecting American Indian youth varies from one locality to the next, but some commonalities exist that impinge directly on the problems of drug and alcohol abuse. The lands allotted to American Indian people were typically those of least economic consequence and were usually in remote areas. In some places, this is rapidly changing with the discovery of natural resources and other forms of economic development, yet it still remains true that American Indian reservations are typically found within the poorest sectors of the country. Despite some changes for the better, poverty and its attendant ills of poor nutrition and health care; stress on all social structures (particularly the family); and inadequate housing, transportation, and other basic support systems are still a way of life in most reservation areas. Young (1994) succinctly summarized the health conditions of American Indians as follows: "The recent epidemiological history of Native American populations appears to be characterized by several key features: decline but persistence of infectious diseases, stabilizing at a level still higher than non-Native populations; rise in chronic diseases, but not quite rampant; and the overwhelming importance of social pathologies" (pp. 52–53).

Education is a further area where inadequacy and a deficit of resources are common on reservations. Historical approaches to the education of American Indian youth were extremely harsh and the use of boarding schools has had an extremely deleterious effect on the family and on other social institutions. It is only recently that American Indian families have taken the opportunity to regain control of the educational systems and to have a central influence in the lives and development of their children.

Despite the negative picture that is generally drawn when describing American Indian youth, there have been recent, dramatic changes in the social fabric of American Indian communities that point to a much brighter future (Beauvais, 2000). Tribes have enthusiastically taken more and more responsibility for their affairs and there is a sense that the coming generations will enjoy a much better quality of life. With respect to drug and

alcohol abuse issues, American Indian communities have been in the forefront of the development of prevention interventions, although, as will be seen, the evaluation of these efforts has been sorely lacking.

Rates and Patterns of Substance Use

It has been recognized for more than 25 years that substance use and abuse has been a significant problem for large numbers of American Indian youth residing on reservations. Pinto (1973) was among the first to bring this to light and to argue for increased resources to address the problem. Subsequently, a variety of studies have demonstrated very high rates of use, although most of these have been on geographically limited populations (e.g., Cockerham, 1975; Dick, Manson, & Beals, 1993; Longclaws, Barnes, Grieve, & Dumoff, 1980). The studies of the Tri-Ethnic Center for Prevention Research at Colorado State University, however, have corroborated these local investigations and have shown higher rates of use for most drugs since 1974 for representative samples of American Indian youth across the United States (Beauvais, 1992, 1996; Beauvais, Chavez, Oetting, Deffenbacher, & Cornell , 1996; Beauvais & LaBoueff, 1985; Beauvais & Oetting, 1988; Beauvais, Oetting, Wolf, & Edwards, 1989; Beauvais & Segal, 1992; Oetting & Beauvais, 1989; Oetting, Edwards, & Beauvais, 1989; Oetting, Edwards, Goldstein, & Garcia-Mason, 1980). These higher rates have been exhibited for lifetime, annual, and 30-day prevalence as well as for an overall index of drug involvement (Beauvais, 1996; Oetting & Beauvais, 1983). In 1992, the Tri-Ethnic Center had access to a large sample of adolescents from around the United States, which included a substantial number of American Indian youth who were not living on reservations. The data showed that non-reservation American Indian youth had levels of drug use lower than American Indian youth living on reservations but higher than their non-Indian counterparts (Beauvais, 1992). The finding leads to the speculation that although reservation life has many positive aspects, there may be environmental variables (e.g., pervasive poverty and unem-

ployment) that promote higher levels of substance use; American Indian youth not living on reservations are not as subject to these harsh conditions. Tri-Ethnic Center studies (Beauvais, 1992; Beauvais & LaBoueff, 1985) and a study by Mitchell and Beals (1997) have shown only minor variation in drug use from one reservation to another, suggesting that the causative factors are common across groups and are not a result of cultural or geographic differences. Boarding school students (Dick et al., 1993; May, 1982) and high school dropouts (Beauvais et al., 1996), however, have a higher incidence of drug use than American Indian youth in general.

Despite having higher rates of use, drug and alcohol use patterns of American Indian youth have paralleled those found for other youth, although they vary over time. Across the United States, there was a substantial increase in drug abuse through the early 1980s and then a steady annual decline through 1992. At that point, use began to rise again (Beauvais, 1996). The latter finding of recent increases has not been substantiated through epidemiological evidence for American Indian youth, but numerous anecdotal reports from local prevention and treatment people on reservations and some preliminary data indicate that a rise in substance abuse is now occurring. Data collection now taking place will help establish the recent trends for American Indian youth. The one exception to the variable pattern over the past 20 years is for those American Indian youth abusing drugs at the most extreme levels. Tri-Ethnic Center researchers have identified a "high-risk" pattern (approximately 20 percent of American Indian 7th–12th graders) that has not changed substantially since 1980.

The pattern of the findings suggests that there is a group of American Indian youth who use drugs for much the same reason as other youth (i.e., are subjected to the same secular influences that vary over time), but that there is another group (i.e., those at high risk) whose drug use is rooted in extreme dysfunction of social and personal resources. For the former, it is reasonable to conclude that prevention programs that work among youth in general and that promote prosocial and normative messages will probably be effective for American Indian

youth. The high-risk youth, on the other hand, are likely to have a host of other social dysfunctions and will require more intense approaches. In one sense, they represent a treatment population.

Etiology and Correlates of Use

While not as extensive as that for other youth, there is a body of literature that examines the etiologic and correlative factors in American Indian adolescent drug use. Some of these studies employ a more broadly based theoretical perspective while others look at single or small groups of variables in a more descriptive approach. At the macrolevel are the study of problem-prone behavior theory (Mitchell & Beals, 1997), social learning theory (Winfree, Griffiths, & Sellers, 1989), and peer cluster theory (Oetting & Beauvais, 1987). The more limited studies have examined discrete sets of variables such as emotional distress, self-esteem, anger and aggression, socialization, knowledge, attitudes, and demographic factors (Austin, Oetting, & Beauvais, 1993). The majority of these investigations have found that there is a great deal of correspondence between the etiologic factors in substance use for both American Indian and non-Indian youth. One of the more general findings across all studies where it is included as a variable is that peer influence appears to mediate nearly all other psychosocial variables in the prediction of substance use (Oetting & Beauvais, 1987). While this conclusion regarding general similarity across ethnic groups is important, a number of studies have demonstrated that there may be relative differences among cultural groups in the influence of peers. For example, in a Tri-Ethnic Center study, Swaim, Oetting, Jumper-Thurman, Beauvais, and Edwards (1993) found that although peers were significant in predicting drug use among American Indian youth, they were considerably less so than for other youth and that family influence regarding drug use was stronger. This same analysis indicated that school had a smaller influence on decisions to use drugs for American Indian youth than for other youth.

There are important implications here for designing prevention programs for American Indian youth in that the family,

rather than the school, should be the main target for interventions. Another difference often found between American Indian and non-Indian youth is the influence of religion on levels of drug use (Austin et al., 1993); religious involvement appears to be a protective factor for non-American Indian youth but has little effect for American Indian youth. This may well be more of a measurement problem; the meaning of religiosity differs greatly between the two groups and scales used to measure this dimension in the general population may not be effective with American Indian groups.

One variable that has attracted considerable attention in the search for etiologic factors is that of cultural or ethnic identification. The prevailing belief is that American Indian youth who have higher levels of identification with their culture will demonstrate lower drug and alcohol use. Despite this strong belief, the research data on this linkage have been extremely meager, not only for American Indian youth but also for all other minority populations (Bates, Beauvais, & Trimble, 1997; Beauvais, 1998; Oetting & Beauvais, 1990–91; Trimble, 1991, 1995, in press). Research to date on this issue has been aimed at finding a direct effect for cultural or ethnic identification, whereas the actual path may be indirect, operating through a number of other psychological and social variables. Given the strong investment among prevention and treatment professionals, examination of the relationship between cultural identification and substance abuse remains a fruitful and necessary area of inquiry.

Regardless of the causative implications of culture on drug use, there is a clear consensus among drug abuse researchers and practitioners that prevention programs must be designed to be culturally appropriate (Beauvais & LaBoueff, 1985; Fleming, 1992; May, 1995; Petrovsky, Van Stelle, & De Jong, 1998; Trimble, 1992, 1995; Trimble, Padilla, & Bell-Bolek, 1987). Programs must include content and activities that are congruent with and promote the values, beliefs, and practices of the aboriginal people of the Americas. The primary reasons for this are respect for the culture of American Indian and Alaska Native communities and to ensure that any program will be acceptable within the communities. Even though a particular approach may have been

shown to be effective in reducing drug use among adolescents in other locations, if it is not accepted as being culturally relevant it will have no chance of success.

In examining the full range of research conducted on American Indian youth, it can be concluded that the majority of it has been focused on problem behaviors with very little addressing healthy or resilient behaviors. At least two authors have noted that unless there is further attention paid to the factors involved in positive adolescent development among American Indian youth, our knowledge of prevention of negative behaviors will be seriously limited (Beauvais, 2000; Mitchell & Beals, 1997).

Prevention

Over the past decade there have been numerous efforts to catalogue and summarize the nature of drug prevention activities among American Indian youth (Hayne, 1993, 1994; Office of Substance Abuse Prevention, 1990; Owan, Palmer & Quintana, 1987). May and Moran (1995) and May (1995) have provided a comprehensive review of drug and alcohol prevention programs among American Indian populations using the public health model of primary, secondary, and tertiary prevention. While it is clear that there is a tremendous amount of activity directed toward preventing drug abuse in American Indian communities, there are only a handful of studies that have applied any rigorous scientific attention to determining effectiveness. May and Moran (1995) concluded, "Few systematic outcome evaluations of either approach (primary and secondary prevention) have been completed in Indian communities. Thus, based on the work in the field to date, we believe that although these approaches have much promise, indications of success should be characterized as preliminary" (p. 297).

Social Skills

Among those few programs that have received some scientific scrutiny are those described by Schinke and Gilchrist and their colleagues (Gilchrist, Schinke, Trimble, & Cvetkovich, 1987;

Schinke, Botvin, et al., 1988; Schinke, Gilchrist, Schilling, & Walker, 1986; Schinke, Orlandi, Botvin, & Gilchrist, 1988; Schinke, Schilling, & Gilchrist, 1986; Trimble, 1992). In the first of these studies (Gilchrist et al., 1987), a skills enhancement program was developed to accommodate local tribal lifeways and administered to a group of young American Indians in the Pacific Northwest. One hundred and two youth (mean age 11.34; 49% female) were screened and half of them were randomly assigned to a program that included health education information about drugs and a series of exercises designed to identify values and to improve decision-making skills regarding future use of drugs and alcohol. Compared with the control group, the experimental youth exhibited lower rates of alcohol, marijuana, and inhalant use (but not tobacco use) at both posttest and 6-month followup. Also noted at both testing periods were reductions in self-perception as a drug user, an increase in knowledge about drugs, and an improved ability to refuse offers to use drugs. In a similar study, which enhanced problem solving by the teaching and modeling of social competence skills, a 6-month followup revealed reductions in abuse of alcohol, marijuana, inhalants, stimulants, and barbiturates (Schinke, Botvin, et al., 1988). Once again, random assignment to experimental and control conditions was used. The latter study is significant in that a social competence component was derived from the theoretical notion that youth who can be trained in bicultural competence (i.e., can function comfortably in both American Indian and non-American Indian society) should display better overall adjustment and lower substance use. This idea is discussed extensively by LaFromboise and Rowe (1983) and LaFromboise, Coleman, and Gerton (1993) and is also consistent with the theoretical framework and empirical findings of Oetting and Beauvais (1990–91) and Oetting (1993).

The idea of the efficacy of bicultural competence training should receive a great deal more attention in future research, given that this is one area in cross-cultural substance abuse research that is solidly based in theory and that has shown some promising empirical results. It is a general model that, if proven efficacious, will have application to other minority populations.

Unfortunately, not much has been done to follow up on the promising work of Schinke or Gilchrist in more than a decade.

Peers

In a pilot study of alcohol abuse with a group of American Indian youth, Carpenter, Lyons, and Miller (1985) found that the incorporation of peer counselors into a prevention program led to significant decreases in alcohol consumption at the end of the intervention and at 4-, 9-, and 12-month followups. This was a very small ($n = 30$), uncontrolled study and the results should be viewed with caution. In another small pilot study, Duryea and Matzek (1990) found some promising results using peer pressure resistance among American Indian elementary school students. While encouraging, the existing studies on peers and drug use among American Indian youth are extremely limited. Given the centrality of peers in the etiology and maintenance of drug-using behavior in general and specifically within American Indian populations, prevention programs incorporating peer dynamics need considerably more investigation.

Family

There is nearly universal agreement that the family is of paramount importance among and within all American Indian groups (Fleming, 1992). While the centrality of the family in the development of children and adolescents is recognized by most cultures, the traditional kinship and extended family structure of American Indian communities add importance to this socialization source. With respect to influence on drug and alcohol abuse specifically, Swaim et al. (1993) have demonstrated that American Indian families may take precedence over peers as the most proximal determinant of abuse or non-abuse. This is contrary to the usual finding of the predominance of peer influence among non-American Indian adolescents (Oetting & Beauvais, 1986).

Given the importance of the family, it is surprising that there is scant literature addressing prevention interventions that feature the family. Hayne (1993, 1994) presented a review of more

than 60 prevention programs on American Indian reservations and in urban American Indian centers. A review of the goals and content of these programs reveals that less than 10 percent focus on the family as one of the more important intervention targets. Most of the programs list activities such as parent training skills, recreational activities to increase contact with the family, drug education for family members, and similar elements, but only a few include the family as a central focus of the interventions. An exception to this is a recently described project by Van Stelle, Allen, and Moberg (1998). The project is built on a 24-week intervention that includes a family weekend retreat, a family drug abuse curriculum, home visits, family support groups, an elders resource council, and cultural activities that bring youth, parents, and elders together. The project enjoyed wide acceptance in the community and many of the existing service agencies participated. Unfortunately, no data were provided on behavioral outcomes.

School-Based Programs

By far the majority of drug prevention programs across the United States are implemented in the school setting, and the situation in American Indian communities is not much different (Owan et al., 1987). A further similarity is the lack of consistent assessment of effectiveness. A few programs have demonstrated specific, short-term gains (Bernstein & Woodall, 1987; Murphy & DeBlassie, 1984), but most lack any evidence that they can be generalized or that the gains are sustained over time. Particularly overlooked is the need for continued booster sessions that seems to be the *sine qua non* of effective school-based programs (Botvin, Baker, Dusenbury, Botvin, & Tracy, 1995). Given the popularity of school-based interventions, it is imperative that more effort be placed in assessing their impact and in determining the dimensions that are required for effectiveness.

Policy

Policy is an area that has received virtually no attention in substance abuse prevention among American Indian youth. In an

exhaustive overview of policy concerning alcohol reduction among American Indian populations, May (1992) found few empirical studies, outside of those examining the effects of alcohol prohibition, which addressed policy topics. Yet, May was able to list no less than 107 potential avenues for alcohol control, based on findings in the general literature and an analysis of policy options available in American Indian communities. It is notable that even as comprehensive as this list is, it did not include issues of school policies regarding drug and alcohol abuse among adolescents. This is a ripe and important topic for research development and program opportunities. Policy options clearly overlap with legal approaches, but again, outside of the studies showing that prohibition has little effect on alcohol consumption in American Indian communities, there are no studies showing how the police and courts can effectively address adolescent drug use prevention in American Indian communities.

Community-Wide Efforts

The past decade has witnessed a growing interest in community-wide prevention efforts and that interest has also been evident in American Indian communities. The impetus for this movement in part comes from disenchantment with the effectiveness of highly targeted and limited prevention interventions. Gorman (1996), for example, reviewed the outcomes of the majority of the school-based prevention programs and concluded that most of them have only a minimal and transitory effect on substance abuse. Given the complexity of and the many interacting social, psychological, and biological elements leading to substance abuse patterns, it is not surprising that a 6-week school curriculum intervention, for instance, will not substantially change drug use patterns among adolescents.

Recognizing the manifold nature of adolescent substance abuse, many in the substance abuse prevention field are recommending approaching the problem on multiple fronts. Certainly the emphasis on community partnerships within the Center for Substance Abuse Prevention, for example, is a reflection of this

stance. The same momentum has been building over the past several years within American Indian communities. May and Moran (1995) and May (1995) conclude from their reviews of prevention activities in American Indian communities that there is a need for a more general, multifaceted public health approach to drug abuse prevention (see also Rolf, 1995). Within the past 5 years the American Indian and Alaska Native Mental Health Research Center has undertaken a major community partnership initiative, funded by the Robert Wood Johnson Foundation, at the University of Colorado Health Sciences Center. Called the *Healthy Nations Project*, the initiative led to the identification of 13 American Indian urban and rural communities in which 5-year prevention projects are now being developed. The projects are designed to be locally initiated and locally controlled efforts that are highly responsive to the cultural beliefs and needs of each location. Each project is expected to develop a variety of networking and intervention activities that address the problem of substance abuse across the continuum from needs assessment through treatment aftercare and relapse prevention. Current descriptions of the progress in these communities reveal an impressive diversity of culturally grounded activities.

The problems involved in any scientific analysis of drug prevention efforts are only magnified when the arena of interest is expanded to encompass multiple community and individual activities and their interactions. Of particular concern is the unique nature of each community coalition and the interventions they define as being appropriate for their locale. The diversity precludes multiple applications of a standard approach that can be compared in an experimental design. A second major problem is the identification of a reasonable control community. American Indian and Alaska Native communities are heterogeneous, not only in their cultural makeup but also in structural characteristics such as size, governance patterns, cultural lifeways and thoughtways, and economic bases. The presence of the heterogeneity creates major doubts as to whether or not external validity can be assured by any design. A third issue is determining the actual level of exposure to any or all of the

coalition efforts. While there may be a plethora of activities taking place in a particular community, it is often difficult to tell which ones, and to what degree, youth may have participated in. In short, assessment of the effectiveness of community coalitions, or partnerships, usually entails fairly loose experimental designs and often, equivocal results.

All of the above problems were inherent in an effort to evaluate a community-based alcohol prevention program on a western reservation by Cheadle et al. (1995). The initial plans for randomization and identification of comparable control communities were stymied by funding considerations. Consequently the control communities were non-Indian locations in another State. Pre-, post-, and followup surveys of youth in the community did show reductions in alcohol and marijuana abuse over a 4-year period. However, similar, albeit smaller, reductions were also seen in the "control" communities and the research team was reluctant to attribute the reductions to the prevention program. Furthermore, the team was unable to document to what extent the youth had been exposed to prevention activities throughout the course of the program.

Community Readiness

It is a common observation among those working with American Indian communities that there is a seemingly endless succession of new drug prevention programs that are brought into communities, thrive while external funding is available, and then rapidly disappear with the cessation of funding. A major element of this circumstance is likely that the communities never had an initial investment in the program (Beauvais & Trimble, 1992). The need for these programs is often not widely recognized or accepted; the programs are usually designed by someone outside of the community and most likely they are not congruent with the culture of the community. Furthermore, many of the implemented programs are so ambitious that they overwhelm the existing resources within the community. For example, a school-based program that requires a considerable financial investment in teacher training and materials will not

work in a reservation school where both dollars and human capital are at the breaking point.

As a response to this mismatch between community needs, perceptions, and attitudes and the need for drug prevention interventions, an approach labeled "community readiness" has been developed that focuses on community dynamics vis-à-vis the acceptance of these interventions (see Jumper-Thurman, Plested, Edwards, Helm, & Oetting, this monograph). The underlying principle of this model is that communities are at different levels in their readiness and willingness to engage in prevention interventions. If the intervention is attempted before the community is ready, or if the intervention is too complex for the level of readiness, then implementation is likely to fail. Note that this model does not address the inherent value or quality of the intervention; an intervention may have been shown to be extremely effective in other locations but will misfire if the community is not ready to accept and implement it.

A critical aspect of the community readiness model is that it is prescriptive as well as descriptive. Descriptively it can be used to objectively measure movement within the community. Prescriptively the model can be used to foster community development. At each stage there are interventions that can be undertaken to move the community along to the next stage. For example, early on (though not at the earliest stages) data such as those from drug surveys can be gathered to further inform and motivate a community to undertake prevention. It is important, however, that these interventions be timed appropriately and conform to what the community is ready to handle. It would be futile and perhaps counterproductive, for instance, to collect drug survey data if the community was exhibiting tolerance toward drug use. Another aspect to the prescriptive nature of this model is that community members themselves provide the data and determine what steps are to be taken to increase readiness. A type of "self-study" is involved where a census of local resources is taken and decisions are made about how they can be used to move forward.

The community readiness model is both qualitative and quantitative. Substantial amounts of interview data are col-

lected in the process of specifying where a community is on the continuum. The end result, however, is a numerical rating that can be used in statistical analyses to determine whether or not a community has changed in their level of readiness as a result of a community development intervention.

Once again, community readiness does not speak to the issue of the effectiveness of any drug prevention strategy. It does, however, provide an accurate gauge for determining at what point certain interventions can be introduced. Without attention to this critical timing, no program, regardless of its demonstrated potency in similar communities, can be effective. It would appear essential that more attention be paid to the community readiness paradigm. At the same time, efforts must continue to examine the specific types of interventions that will be effective in American Indian communities.

Cultural Sensitivity

There are a number of requirements that must be recognized and attended to when the research enterprise crosses cultural boundaries. Failure to do so has led to the failure of many research efforts, which for obvious reasons do not show up in the literature. (See Manson, 1989 for an exception.) Trimble (1977), Rolf (1995), and Beauvais and Trimble (1992) discuss many of these requirements, including access to research populations, trust, collaboration in the design of researchable ideas and in the research process, measurements that capture concepts crossculturally, and the interpretation and dissemination of results from a cultural perspective. Petrovsky et al. (1998) recently described a community-wide drug prevention program in an American Indian community that not only demonstrated positive outcomes (substance use rates were lower than those of a comparison community) but also conformed to cross-cultural research requirements. Each of the four components of the intervention was designed through extensive discussions with community members; this took an extended period of time but was necessary to establish the legitimacy and relevance of the research project. In addition, community members

were included as staff. Problems and interim project outcomes were discussed with local people in an effort to adjust the goals to not only be scientifically rigorous but also to meet the needs of the local community. Results of the study included both quantitative and qualitative comparisons; the latter were most useful to the community in terms of determining the impact of the intervention.

Monograph Contents

The contents of this monograph represent the longstanding and dedicated commitment of the authors to reducing and eliminating the harsh consequences of alcohol and drug abuse in American Indian and Alaska Native communities. The chapters are thin slices of the realities of daily life in American Indian and Alaska Native communities and thus represent a very small portion of what can be said about the entire topic. Nonetheless, each chapter represents at a minimum what one must know to work effectively in American Indian and Alaska Native communities in the prevention field.

The core theme of each chapter reflects on the importance of family and community in designing and implementing prevention strategies in American Indian and Alaska Native settings. James Moran provides the historical context of prevention efforts in American Indian communities and outlines some of the current barriers to program development. He then reviews the primary, secondary, and tertiary prevention work over the past few years and from that review draws a number of principles that should be adhered to in future programming efforts. Grace Powless Sage provides a different context in describing American Indian approaches to healing that differ from those typically seen in drug intervention programs. She then argues for a synthesis of the holistic approaches from the American Indian worldview with "traditional" drug prevention activities. Gerald and Justin Mohatt and Kelly Hazel provide yet a different context. The vast expanses of Alaska present numerous challenges to prevention within Alaska Native villages; however,

they describe numerous initiatives at the State, regional, and local levels that are responsive to the demographic and cultural needs of Alaska Natives. Pamela Jumper-Thurman and her colleagues expand on the community readiness theme and describe its application to a variety of prevention programs for American Indians. The process of assessing community readiness is fully described. Jeannette Johnson and her team address community perceptions of and effectiveness of the National Association of Native American Children of Alcoholics. Rich ethnographic data are included to illustrate their conclusions. Finally, Fred Beauvais addresses the issue of the effectiveness of school-based prevention programs in American Indian communities. His article ends with a strong recommendation that American Indian families, rather than schools, should be the primary focus of prevention in American Indian communities.

It is our sincere hope that the material in this monograph will serve to strengthen everyone's resolve to reduce the incidence and prevalence of alcohol and drug abuse and of life-threatening illnesses occurring among many of the indigenous peoples of the Americas. We sincerely hope that American Indians and non-American Indians will benefit constructively from the information and seek ways to follow through on the recommendations.

Summary and Future Directions

Much can be written about the present and future status of prevention programs designed for use in American Indian and Alaska Native communities. Certainly, there are few published articles about research findings on American Indian prevention programs and thus there is a desperate need for more research on the topic; the etiologic findings support such a recommendation. The material summarized and presented in this introductory chapter sets a tone that demands attention. From the prevention and etiologic literature that does exist, the following conclusions can be drawn with respect to effectiveness of prevention and intervention activities among American Indian youth:

1. The centrality of the family in American Indian culture makes it imperative that it is involved in prevention approaches.
2. Peers exert a significant effect on decisions about drug use, although to a lesser degree than among non-American Indians.
3. As currently defined and measured, cultural identification is not directly related to substance abuse prevention although it may be critical in treatment.
4. Many of the factors affecting youth in general also impact drug use among American Indian youth.
5. Much more is known about risk than resiliency factors for American Indian youth.
6. The evidence for the effectiveness of school-based programs is very limited.

As a consequence of Manson's 1982 seminal work, in 1984 Trimble outlined a series of recommendations directed towards the advancement of prevention strategies, themes, and research among American Indians and Alaska Natives. According to these recommendations, researchers should consider these questions:

1. What forms of drug and alcohol use are thought to be preventable? By what indigenous and tribally specific means?
2. What are the models of human and transcultural competence "in terms of individuals, families, and communities" that account for the immense heterogeneity among American Indians and Alaska Natives? How can these models drive prevention and intervention strategies?
3. What are the characteristics of natural support systems? What are the traditional ways of changing and strengthening those systems to advance the prevention of substance use and abuse, of illness, and of individual and social deviance?
4. What culturally appropriate information about the causes and consequences of substance use and abuse, illness, and deviance is available for circulation and use in American Indian and Alaska Native communities? What procedures

are available to assist American Indians and Alaska Natives in turning cognitively based information into behavioral skills to assist them in coping with situations involving alcohol and drugs?

5. What are the psychosocial characteristics associated with the lifespan predictors of substance use and misuse? What are the age-specific gender differences and characteristics?
6. What treatment modalities (indigenous and traditional) are available to effectively deal with substance use and misuse? What expectancy variables define treatment, the therapeutic relationship, and aftercare? From the American Indian's point of view? From the intervenor's point of view?
7. Under what conditions and for what reasons are practices and techniques of traditional healers and shamans appropriate for dealing with American Indian and Alaska Native substance use and misuse? What are the ethical issues associated with changing the shamanic traditions to accommodate conventional forms of health and wellness interventions, including psychiatric and conventional psychological approaches?

Although these recommendations are 16 years old, they still hold relevance and promise for setting an agenda for future work.

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2

Prevention Principles for American Indian Communities

James R. Moran

Abstract

As a group, American Indians experience many problems related to alcohol misuse. Age of first involvement with alcohol is younger, frequency and amount of drinking is greater, and negative consequences are more common for American Indians than for non-Indians. However, there are prevention approaches that work to reduce risk of alcohol misuse among American Indians. Based on an examination of these approaches, this chapter identifies prevention principles that may increase the likelihood of success when working with American Indian communities. These principles relate first to the ways that prevention workers carry out their work in American Indian communities and second to types of strategies used in the prevention programs. The concern in both areas is to identify general principles that are appropriate for American Indian communities.

The purpose of this chapter is provide an overview of some of the typical prevention efforts that have taken place in American

Indian communities and to identify common themes or *best practices* among them. These practices fall into two areas. The first area addresses the manner or process by which prevention workers carry out their work in American Indian communities. The second area relates to the content of the prevention efforts. The concern in both areas is to identify specific principles that are appropriate for American Indian communities.

Although this chapter focuses on programs for the prevention of alcohol misuse, the issues addressed apply generally to the prevention of all drug misuse. This is important since drugs other than alcohol present major problems in American Indian communities. Recent work by Okwumabua and Duryea (1987); Swaim, Oetting, Edwards, and Beauvais (1989); Beauvais (1992a), and Mail and Johnson (1993) provide good overviews of the range of drugs and related problems experienced by American Indians. For example, inhalants are frequently abused by American Indian youth, especially by young adolescents before they gain access to alcohol (Beauvais, Oetting, & Edwards, 1985a; Wingert, 1982); use of marijuana is highly variable across different American Indian groups, but appears to be higher among American Indian youth than non-Indian youth (Mail & Johnson, 1993); heroin use is very low among American Indian people (Bachman et al., 1991); and cocaine use is similar for American Indians and non-Indians (Beauvais et al., 1985a). After reviewing the evidence from several national studies, Mail and Johnson (1993) concluded that the availability and predictability of effects have made and continue to make alcohol the drug of choice among American Indian people.

This chapter begins with an overview of population characteristics that provide important background information for prevention workers planning to work with American Indians. Next, the extent of the problem of alcohol misuse is described. Third, how prevention work is carried out in American Indian communities is examined in an effort to identify principles that will guide workers in carrying out successful programs. Finally, several prevention approaches are reviewed for the purpose of drawing out some of the practices that are emphasized in American Indian programs.

The American Indian Population

As of 2000, there were 557 federally recognized tribes (Indian Health Service [IHS], 1999). While some similarities exist among these groups, there is also significant variation as evidenced by many distinct cultural areas (Manson, Shore, Barron, Ackerson, & Neligh, 1992) and more than 200 currently spoken American Indian languages (Fleming, 1992). Persons defined as American Indians may also differ greatly by degree of Indian ancestry, with 25 percent American Indian blood the most commonly accepted minimum threshold for tribal membership (Wilson, 1992).

All of this is further complicated because, like members of other ethnic groups, most American Indians live in two worlds: their own ethnic community and the mainstream or white community. This experience of dual socialization has been conceptualized as primary enculturation experiences within one's own cultural group along with less comprehensive, but significant exposure to agents and forces within the majority culture (de Anda, 1984). Valentine (1971) pointed out that all ethnic minority groups are exposed to dominant cultural patterns by mainstream institutions, including the mass media, advertising, public schooling, and national holidays and heroes. Another layer of American Indian diversity is intertribal and interracial marriages that may result in many American Indian people affiliating with more than one tribe, being of mixed blood, or both. Indeed, throughout the 20th century, mixed-blood American Indians have outnumbered full-blood Indians (Wilson, 1992).

Geographically, American Indian populations tend to cluster in the Western States with 66 percent of all American Indians living in 10 States. Of these 10, 8 are in the West or Midwest (Hodgkinson, Outtz, & Obarakpor, 1990; Snipp, 1989). While American Indian people are often thought of as residing on isolated reservations, the majority live in urban environments or migrate to and from reservations and urban areas (Hirschfelder & Montano, 1993; U.S. Census Bureau, 1992). Finally, as a result of a birth rate that has consistently been twice that of the U.S.

average, the American Indian population is young. The median age of the American Indian population was 24.2 years in 1990, compared with 34.4 years for U.S. whites (IHS, 1993).

Extent of the Problem

Alcohol misuse leads to a number of problems for many American Indian communities. For example, as a group, American Indians and Alaska Natives experience high rates of heart disease, cancer, diabetes, and injuries and death due to accidents (IHS, 1991). Alcohol misuse plays a significant role in all of these problems. Both inpatient and outpatient data of the IHS show alcohol-related trauma and diseases to be frequent reasons for health care and disability (Hisnanick & Erickson, 1993; IHS, 1993).

Further, American Indians have a higher rate of alcohol-related death than the general U.S. population. For example, in the age group 25 to 34, American Indian males die 2.8 times more frequently than non-Indian males from motor vehicle crashes; 2.7 times more frequently from other accidents; 2.0 times more frequently from suicide; 1.9 times more frequently from homicide; and 6.8 times more frequently from alcohol dependence syndrome, alcoholic psychosis, and chronic liver disease and alcoholic cirrhosis combined (May, 1995). In summary, alcohol is a major factor in 5 of the 10 leading causes of mortality for American Indians (IHS, 1992). American Indian males have a greater problem with alcohol-involved death than American Indian females; alcohol-involved mortality data are worse for both American Indian males and females than the overall U.S. averages; and the disparity between American Indians and the U.S. general population is greatest in the younger age groups (May, 1986, 1989).

Much of the American Indian-related alcohol research concentrates on young persons and an examination of some of these findings can be instructive regarding appropriate prevention efforts. American Indian youths generally report that they use alcohol as frequently or more frequently than other youths in the

United States. For example, by the 12th grade, lifetime prevalence of alcohol use is quite high: 96 percent for American Indian males and 92 percent for females (Oetting & Beauvais, 1989). But the major difference between American Indian youth data and U.S. youth averages is found in measures dealing with age at first involvement and degree of involvement. Age at first involvement with alcohol is younger for American Indian youths, frequency and amount of drinking are greater, and negative consequences are more common and severe (Beauvais, Oetting, & Edwards, 1985b; Forslund & Cranston, 1975; Forslund & Meyers, 1974; Hughes & Dodder, 1984; Oetting, Beauvais, & Edwards, 1988). Oetting and colleagues (1989) have found that at all ages and grades, a greater percentage of American Indian youth are more heavily involved with alcohol than are non-Indians. Several studies indicate that heavy drinking is both encouraged and expected among many peer groups as the "Indian thing to do" (Winfree & Griffiths, 1983a). Beauvais and LaBoueff (1985) indicate that the youth most likely to abuse alcohol are those tied to alcohol and drug abusing peer clusters. By 12th grade, 80 percent of American Indian youth are current drinkers, but there is some variation from reservation to reservation (May, 1982). Severity measures show that American Indian youths who drink are more likely to report having been drunk and to have "blacked out" (Oetting & Beauvais, 1989). Just as U.S. high school data show an increase in drinking and marijuana use through 1980, and subsequent declines after 1980, the American Indian patterns over time are similar. That is, American Indian youths have reported reduced use of drugs and alcohol in recent years (Oetting & Beauvais, 1989; Winfree & Griffiths, 1983b). However, the subgroup of American Indian youths who indicate heavy use has not declined but rather has remained steady at 17 percent to 20 percent (Beauvais, 1992a).

Ferguson (1968) has described the majority of American Indian drinking as recreational drinking. She indicated that the subgroup of recreational drinkers is typically made up of young males who drink with friends for weekends, parties, special occasions, and other social events. As with other groups of young persons, drinking and intoxication are important for

social cohesion and are generally highly valued. This type of recreational drinking among American Indian groups of many tribes may differ from some other groups in the United States only in matters of degree and cultural meaning. As described by many authors, American Indian recreational drinking is more rapid, more forced, and the "bouts" are extended over long nights, entire weekends, and for other lengthy periods (Dozier, 1966; Hughes & Dodder, 1984; Lurie, 1971; Savard, 1968; Weisner, Weibel-Orlando, & Lang, 1984). Very high blood alcohol concentrations are commonly found in American Indians who participate in this style of drinking.

Both the data on the extent and the consequences of use clearly point to the need for programs for preventing alcohol-involved problems, especially among American Indian youth. Differences by tribal group, cultural orientation, degree of American Indian ancestry, and reservation or urban residency prohibit the prescription of what prevention should look like in all American Indian communities. However, by examining approaches to working in American Indian communities and the range of prevention programs operating in these communities, it is possible to arrive at some prevention principles that are applicable for working with American Indians.

Working in Indian Communities

Overcoming Distrust

One of the first issues to consider in understanding the dynamics of carrying out prevention programs in American Indian communities is that like many other ethnic minority communities, American Indian communities often have a historical distrust of the dominant society (Lockart, 1981). This distrust is based in the historical nature of the relationship between the dominant culture and American Indians that includes a 500-year history of oppression and domination—at times approaching genocide. When the programs are seen as imposed from outside the community, this distrust is likely to escalate and to form a significant barrier. In such situations, prevention programs are

not likely to produce useful results. To overcome this, we must find ways to make programs relevant to communities and we must demonstrate our commitment to the community. A key part of making programs relevant is to have them emerge out of the process of community involvement. Beauvais and LaBoueff (1985) present a model of community action that progresses from a few interested people to a core group to a community task force. Each step involves more community members committed to the idea of prevention.

There are several ways that noncommunity members can demonstrate their commitment to American Indian communities (Fred Beauvais, personal communication, August 15, 1997). Simply responding to the stated needs that are defined by the process of community involvement instead of having a set program that is defined by academic interests or by government or foundation announcements is a strong statement to the community. Providing technical assistance that is needed in the community even though it may not be funded directly by grants also contributes to demonstrating a commitment. Perhaps most important, prevention workers need to be willing to stick around and deal with a problem for as long as it takes, even if that means moving beyond the original funding period. This might mean locating and securing additional funding in order to continue a program. In summary, working in American Indian communities requires us to directly address issues of distrust by listening to and then responding in a committed manner to community-defined interests.

Developing Cultural Sensitivity

To accomplish the above, we must be culturally sensitive. But what does that really mean? Much work has been done concerning the overall issues of cultural diversity and cultural sensitivity. Tello (1985), Cross (1988), Cardenas (1989), and Orlandi (1992) refer to this area of work as cultural competency. While varying slightly, these authors view competency as occurring in stages with simple awareness of cultural differences being a necessary first stage. The second stage is self-assessment, that

is, the awareness of one's own cultural values. This approach to cultural competence holds that people must understand their own culture (i.e., recognize that they have a cultural lens) before they can be sensitive to other cultures. The third stage is an understanding of the dynamics such as conflict and racism that may occur when members of different cultures interact. Working through these three stages enables individuals to adapt to diversity and to adjust professional skills to fit within the cultural context of the ethnic community. Green (1982) clarifies this process by pointing out that to be culturally competent means to conduct one's professional work in a way that is congruent with the behaviors and expectations that members of a cultural group recognize as appropriate among themselves. He states that it does not mean that nonmembers of a community will be able to conduct themselves *as though* they are a member of the group. Rather, they must be able to engage the community on something other than their own terms and demonstrate acceptance of cultural difference in an open, genuine manner, without condescension.

To expand on this issue, the term culture must be given substance. Lum (1986) summarizes many of the ideas concerning culture. He indicates that culture deals with the social heritage of humans. Culture is the way of life of a society: prescribed ways of behaving or norms of conduct, beliefs, values, and skills. It is the sum total of life patterns passed on from one generation to the next within a group of people. Culture is a code that guides interpretation of behavior. Orlandi (1992, p. vi) puts it this way, "culture is the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people."

From the above it is clear that culture is not static but is constantly being altered. Indeed, cultures can be viewed as living, evolving systems where over time some cultural traits remain, some change, and others are discarded (Attneave, 1989). A common, albeit, limited view of cultural change is that it occurs along a single continuum from "traditional" to "modern." Drawing attention to this perspective is important both because it is common and because it can lead to the devaluing of

American Indian culture (Beauvais, 1989). Inherent in this linear view of cultural change is the idea that people move from the old to the new and that while in transit, they are confused—experiencing stress and in general not able to function competently. Something of the old is lost when one embraces the new. These themes of loss, confusion, and stress emphasize the negative aspects of cultural change and represent a limited view. In other words, this view of cultural change as occurring along a single continuum from traditional to modern contributes to a lack of cultural sensitivity.

A promising alternative view of cultural change is the concept of biculturalism. Biculturalism is the ability to function effectively in the mainstream culture and yet maintain positive and significant cultural connections to the ethnic community. Oetting and Beauvais (1990–91) refer to this approach as "orthogonal cultural identity" with the term *orthogonal* drawing attention to the idea that people are capable of identifying independently with more than one culture. McFee (1968) describes how some American Indians in his research shifted their frame of reference when interacting with whites and then shifted back again when dealing with members of their Blackfeet community. He formed the metaphor of *150% man* to point out that for his respondents, cultural change was not a journey of loss but rather one of gain. The bicultural approach introduces the possibility of increased cultural sensitivity because it allows equal treatment and coexistence of cultures rather than requiring the movement from traditional to modern. The bicultural view is particularly important in work with urban American Indian communities where by necessity community members live in two worlds—their Indian culture and the mainstream or dominant culture.

To be culturally sensitive, one needs to gain an understanding of the meaning of the institutions, values, religious ideals, habits of thinking, artistic expressions, and patterns of social and interpersonal relationships that influence the lives of the members of the community in which the research is to take place. Clearly this is not a simple task and how well nonmembers of a culture can accomplish this may vary. However, the

alternative of ignoring culture in working with American Indian populations relegates our efforts to be of little importance to these communities.

A useful starting point in thinking about cultural sensitivity is to focus on values. Some authors have developed typologies that compare dominant and other, primarily ethnic, cultural values. Randall-David (1989) compares common values of "Anglo" and "Other Ethnocultural" groups. In general, this typology fits well with the values found in many American Indian communities. She indicates that "Anglos" value mastery over nature, doing, and individualism, while other groups value harmony with nature, being, and group welfare. It is important to note that this approach treats culture as a dichotomy, comparing white values with the values of other cultural groups. Although there are indeed many similarities among broad cultural groups of American Indians, this typology and others like it carry the risk of lumping together all white and all American Indian cultures and attempting to treat them as if there are only two large cultural groups. The limitation of this is apparent when one considers the diversity in tribal affiliation, language, degree of American Indian ancestry, and reservation or urban residence that is found in the American Indian population.

So why use such a framework at all? Taking these cautions and limitations into account, this dichotomous approach remains useful as an overview in helping to sort out possible areas of cultural difference. It draws attention to the idea of differences and gives prevention workers direction in understanding the meaning of culture for themselves and for their target populations. Use of such frameworks can be of assistance in working through the first two steps of cultural competency, those of acquiring an awareness of cultural differences and becoming aware of one's own culture. In other words, this approach is a reasonable starting point for more in-depth inquiry into the issue of cultural sensitivity.

After this starting point of examining differences in cultural values, what comes next? Given the range of cultures that exist and the amount and kind of knowledge that is necessary in

order to carry out prevention work in a way that is compatible with the culture of the American Indian community, how can workers attain more depth in terms of cultural sensitivity? The simple answer is: Because the culture of each community varies, there is no substitute for direct and extended involvement. However, gaining access to a community is not always an easy task. In American Indian communities, one of the first steps in gaining access is to describe the intent, nature, and benefits of a possible project before the governing body (Beauvais & Trimble, 1992). On reservations, identification of the governing body is clear-cut and is normally the Tribal Council. Urban American Indian communities do not have a governing body; however, a parallel step might mean meeting with a group composed of representatives from the major American Indian organizations. In addition, a community meeting open to all American Indian people could be used to explain the purpose, costs, and benefits of the program. It is important to note that the purpose of such meetings is both to show respect for the community by presenting ideas about proposed work and, perhaps more important, to obtain feedback from the community. The point of this process is that a significant part of being cultur-ally sensitive is to have the sanction of the community. Without the sanction, whether it is formal or informal, noncommunity members will always be seen as outsiders and hence be frustrated in further attempts to establish credibility.

In addition to obtaining community support, culturally sensitive prevention work involves the community in the actual process from start to finish (Davidson, 1988). The prevention team might include the technical program people, a broadly constituted steering committee, and local colleagues (Mohatt, 1989). To every extent possible, community members should be employed as part of the team. This team should then meet as a group throughout the program to determine and monitor the specifics of implementation, of explanations to the community, and of reporting results.

While not addressing prevention programs directly, Shore (1989) outlined many of the steps necessary for culturally sensitive work in American Indian communities. The elements of his

schema include the following: (1) the planning should begin with collaboration with the community; (2) the focus of the work should be compatible with local priorities; (3) the design and selection of a particular program approach should consider the relevance of the outcome for use by the community; and (4) the program should be implemented in a local community partnership with an attempt to employ community members as staff whenever possible. Again, the community action model proposed by Beauvais and LaBoueff (1985) incorporates all of these ideas and can certainly be instructive for prevention workers contemplating work in American Indian communities.

Approaches to Prevention

In a review of more than 50 programs that have been implemented in American Indian communities, May and Moran (1995) identified many issues that can guide prevention efforts. Generally the prevention literature is divided into tertiary, secondary, and primary prevention. Because there are different interpretations of these terms, it is important to clarify that this chapter will use these categories as defined by Last (1983). *Tertiary prevention* consists of measures taken to reduce existing impairments and disabilities and to minimize suffering caused by severe alcohol misuse or alcohol dependence. *Secondary prevention* uses measures available to individuals and populations for early detection within high-risk groups and for prompt and effective intervention to correct or minimize alcohol misuse in the earliest years of onset. *Primary prevention* is the promotion of health and elimination of alcohol abuse and its consequences through community-wide efforts, such as improving knowledge; altering the environment; and changing the social structure, norms, and values. Use of these categories allows the consideration of diverse programs that focus on different but related aspects of the problem. The programs described here were selected because they demonstrate the many approaches used in American Indian communities. Some of what is in place

is distinct to American Indian programs while much is common to prevention programs in other communities as well.

Tertiary Prevention

Given the magnitude of the problems related to alcohol misuse that exist in many American Indian communities, programs that emphasize tertiary strategies with alcohol abuse are important parts of an overall prevention strategy. Although secondary and primary strategies may hold the ultimate hope for healthy communities, we cannot ignore the problems of those currently alcohol-dependent.

Weibel-Orlando (1989) describes some of the typical methods used in tertiary prevention programs with adult American Indian alcoholics. She reports on a survey of 26 federally funded rural and urban treatment programs and compares them across factors such as ethnicity of staff, strength of affiliation with Alcoholics Anonymous (AA), cooperation with tribal healers, and treatment effectiveness. Most of the staff in the surveyed programs were American Indian. This was seen as positive, because non-Indian counselors often faced reactions ranging from overt hostility to sullen resistance. Most of the programs had a strong AA affiliation; however, this was seen as primarily related to the AA background of almost all of the counselors. Finally, most of the programs were accommodating to cultural practices. On the low end, this involved the display of American Indian posters and handicrafts, while programs with more cultural involvement often included such things as sweat lodges and use of a sacred pipe during prayer ceremonies. However, traditional American Indian healers played only a minor role in the 26 programs. Weibel-Orlando states that several of the medicine men she interviewed expressed doubt that traditional healing practices are appropriate in typical treatment settings and that most traditional healing is tribal-specific and not available to outsiders. She concludes by calling for a more local focus for treatment programs, in order to enable increased cultural involvement.

Jilek-Aall (1981) describes some modifications made to the traditional AA approach that appeared to have success with the Coast Salish people of the Northwest. For example, rather than being limited to the recovering person, attendance at meetings was open to other family and community members. In addition, participants were free to come and go as they chose and when speaking were encouraged to talk as long as they wanted. This more open structure allowed tribal participants to incorporate cultural activities as part of the program. Others (Coggins, 1990; personal communication, February 9, 1998) have developed cultural approaches that directly tie the 4 directions of the medicine wheel to the 12 steps of AA.

In a similar vein, Albaugh and Anderson (1974); Pascarosa and Futterman (1976); and Blum, Futterman, and Pascarosa (1977) describe Native American church practices and peyote as therapeutic agents that can treat problems with alcoholism. These authors describe the therapeutic efficacy of using the values, beliefs, structure, and rituals of the Native American church to treat and prevent further problems that result from alcoholism.

Watts and Gutierres (1997) interviewed American Indian clients at three residential treatment facilities in Arizona. This qualitative work focuses on clients' views of the recovery process. A major theme from this study is the importance of family and community. For many of the participants it was the intervention of significant members of their family and community networks that facilitated their entry into treatment. During the treatment programs, elderly family or community members were often cited as more important to recovery than the program counselors. The lesson for prevention programs is that practices such as talking circles, sweats, and powwows should be structured in such a manner as to facilitate active involvement of the American Indian clients' networks.

Ferguson (1976) explores the use of stake theory to understand the outcomes of a treatment study of Navajo chronic alcoholics. This is a fairly straightforward theory that holds that those who have a stake in society will conform to society's norms and demonstrate less deviance such as alcohol misuse. She

found that those with a stake in the Navajo society or a stake in Western society responded better than participants with a stake in neither. However, those with a stake in both Navajo society and Western society had the most treatment success. One possible explanation of these results is based on the work of Lewin (1948), who indicates that individuals require a strong sense of group identification to maintain a state of well-being. Ethnic identity is a critical component of group identification and is considered by many as crucial to self-concept and psychological functioning (Gurin & Epps, 1975; Maldonado, 1975). In a sense, having a stake in a segment of society is similar to identifying with that segment. Oetting and Beauvais (1990–91) found that American Indian respondents who did not identify strongly with any ethnic group (marginalization) tended to score low on psychological measures of well-being; those who identified with either their ethnic group or mainstream white society (separation or assimilation) scored higher; and those who strongly identified with both their ethnic group and the mainstream society (biculturalism) tended to have the highest scores.

Similarly, Moran, Fleming, Somervell, and Manson (1996), in a study of nine high schools located in American Indian communities, sorted American Indian adolescents into low and high identity on the basis of their identification with both American Indian and white cultures. The result was four groups: (1) low identification with both American Indian and white cultures; (2) high identification with American Indian culture only; (3) high identification with white culture only; and (4) high identification with both American Indian and white cultures. The relation of those four groups to psychological well-being as defined by the respondents' perceptions of their social competencies, personal mastery, self-esteem, and perceived social support was examined. For all of the measures of positive psychological well-being, the mean values across the four groups were different at statistically significant levels. Further, the lowest scores occurred for those with low identification with both American Indian and white cultures, middle range scores were obtained by those with high identification with only American Indian or only white culture, and the high-

est scores occurred for those with high identification with both American Indian and white cultures. The implication of this work by Ferguson (1976), Oetting and Beauvais (1990–91), and Moran et al. (1996) is that programs at all levels of prevention (tertiary, secondary, and primary) can probably benefit by consciously addressing issues of culture in a manner that fosters stronger identification and thus enhances participants' stake in both their American Indian society and Western society.

Secondary Prevention

A majority of the secondary prevention programs aimed at American Indians in recent years have been school-based initiatives that emphasize information about the effects and consequences of substance abuse. Programs such as "Here's Looking at You," "Project Charley," and "Babes" have been used in many American Indian communities, both on and off reservations (May & Moran, 1995). The consistent themes in school-based substance abuse prevention programs are building bicultural competence (LaFromboise and Rowe, 1983), increasing self-esteem and self-efficacy (IHS, 1987), improving resistance to peer pressure and overall discriminatory and judgment skills (Duryea & Matzek, 1990; Gilchrist, Schinke, Trimble & Cvetkovich, 1987; Schinke, Orlandi, Botvin, Gilchrist, Trimble, & Locklear, 1988; Schinke, Schilling, Gilchrist, Asby, & Kitajima, 1989), and increasing the perception of the riskiness of alcohol and drug use (Bernstein & Woodall, 1987). The current literature supports these approaches if they are undertaken in combination. That is, building self-esteem alone is not likely to reduce alcohol use, while building new perceptions, values, skills, and support systems along with increasing self-esteem may be beneficial. Newcomb and Bentler (1989) indicate that in addition to single targets such as self-esteem, these programs must also affect the social and cultural aspects of life and mitigate peer group pressure. This can be accomplished by either direct or indirect influence, but the sociocultural aspects must be addressed in addition to the mental health and psychological issues (Oetting & Beauvais, 1989).

Moran (1999) reports on a secondary prevention program that targeted urban American Indian youth. The program was conceptualized and based on two sources of expertise. It built directly on the prevention research and it also involved the local American Indian community through a process of community meetings and focus groups. From the literature came the general approaches of (1) correcting inaccurate stereotypes that overemphasize the amount of alcohol use; (2) developing a conflict between personal values and alcohol use; (3) enhancing self-esteem; (4) teaching a structured way for making good decisions; (5) learning and practicing skills to resist peer pressure; and (6) making a personal commitment to not use alcohol. These approaches were chosen because they have demonstrated effectiveness across ethnic groups (Hanson, 1993).

In order to address culture in a meaningful way, the local American Indian community was systematically involved in identifying a unifying theme for the program. Meetings with various groups of American Indian people were held to discuss what was needed in the community and to provide details about the study. This process resulted in a name for the project: the Seventh Generation. From an American Indian cultural perspective, this is more than just a name. Among the Lakota, who represent the majority of American Indian people involved in the meetings, the phrase refers to a time of healing, a time for American Indian nations to come together. Today's American Indian children are considered to be the seventh generation. Thus, using this name for an alcohol prevention program targeting American Indian youth carries a powerful message within the community.

A second meaning of the term derives from placing the children in the center of seven generations. For American Indian people this conceptualization fits well with prevention efforts. Namely, children must remember the wisdom of their elders (parents, grandparents, and great-grandparents) when making decisions and they must also consider the impact of their decisions on those who will come after them (children, grandchildren, and great-grandchildren). This multigenerational view fits

well with the concept of responsible decision making and became the focal point for much of the program.

In addition to the program's name, the up-front involvement of the community also resulted in a way to incorporate American Indian culture in a manner that was meaningful to urban American Indians. After several meetings an agreement emerged that a set of core values transcended tribal differences. After generating a list of more than 20 values, the participants narrowed the list to 7: Harmony, Respect, Generosity, Courage, Wisdom, Humility, and Honesty. These values reflect many American Indian cultural concepts such as the *Medicine Wheel* of the Northern Plains or the Navajo terms *Hozho* and *Walk in Beauty*. Thus, rather than using cultural artifacts such as the teaching of American Indian arts and crafts, the Seventh Generation Program was developed in a manner that incorporated cultural values as the core organizing framework for the program. The parallel paths of development (i.e., utilizing both the prevention literature and key knowledge from the community) exemplify the principle of meaningful community participation in the development and implementation of prevention programs.

Primary Prevention

The philosophy of primary prevention among American Indian people calls for broad programs of health promotion, particularly those that emphasize community change. May (1986) stresses primary prevention through social policy, environmental change, and broad-based action for normative change. The Office of Substance Abuse Prevention (OSAP, 1990) focuses on both mental health and substance abuse programs for prevention and concludes with an emphasis on comprehensive prevention. Mail (1985) lays out a rationale and a number of specific considerations for primary prevention initiatives in American Indian communities, while Mail and Wright (1989) indicate that successful prevention programs will have to come from the communities themselves.

Beauvais (1992b) pinpoints socioeconomic conditions as the major factor that has contributed to substance abuse in American Indian communities. He proposes an integrated model of prevention that focuses on improvement in (1) social structure (economics, family structure, and cultural integrity); (2) socialization (family caring, sanctions, and religiosity); (3) psychological factors (self-esteem and reduced alienation); and (4) peer clusters (peer encouragement for nonuse and sanctions against alcohol and drug use). Beauvais believes that this will ultimately lead to lower levels of alcohol and drug use. This is similar to the work of Beauvais and LaBoueff (1985), in which the comprehensive community action approach is advocated, an approach that should be implemented in a collaborative manner from within the community rather than from the top down.

Beauchamp (1980) reiterates the community focus in a four-step approach to the process of primary prevention in American Indian communities. First, there should be a focus on building consensus around which aspects of alcohol-related behavior can and must be addressed for the benefit of the larger community. Second, a definition of safe or nonproblematic drinking patterns should be developed. This is an important step since nonproblematic drinking is not an appropriate target for prevention efforts. Third, approaches to reduce unsafe drinking practices and encourage nonproblematic practices should be planned and carried out. Fourth, there should be a focus on broad community support for all efforts at reducing unsafe drinking practices. Beauchamp's point is that both problem definition and solution should be collective efforts.

May (1992) provides an overview of several specific primary prevention strategies that can be used. First is the regulation of alcohol supply through raising taxes, limiting and controlling the number and types of alcohol outlets, enforcing strict age limits on alcohol use, discouraging advertising targeted at vulnerable groups, and enforcing current reservation laws. This latter point deserves further comment. Until 1953, Federal law prohibited alcohol on all reservations and since that time only about 30 percent of reservations have voted to allow alcohol. In other words,

prohibition continues on approximately 70 percent of current reservations. Strict enforcement of such laws might reduce the level of alcohol-related problems. On the other hand, prohibition does not seem to have worked well since bootlegging is common on dry reservations and availability of alcohol at off-reservation sites often results in an increase in the risk of intoxicated driving. An argument can be made that a more rational policy would be legalization of alcohol with strict and enforceable guidelines focused on reducing unsafe drinking practices.

The second strategy presented by May (1992) focuses on this last point, namely, reducing unsafe drinking and promoting safe and appropriate drinking. Drinking behaviors that communities have found unacceptable are driving under the influence, chronic intoxication, alcohol-related violence, public inebriation, and alcohol consumption by pregnant women. Laws limiting each of these behaviors could be enacted and enforced. Further, public education regarding the negative impact of these drinking practices should be carried out through school programs and media campaigns targeting all community members.

The third strategy emphasized by May (1992) focuses on reducing environmental risk. Some of these measures are increasing the use of passive restraints such as seat belts, air bags, and infant seats; promoting designated-driver and safe-ride programs; mandating server training; supporting domestic violence shelters; and focusing enforcement efforts on drinking establishments that produce the most public drunkenness and other alcohol-related problems.

There are several examples of these strategies in American Indian communities. Marum (1988) describes the community-generated prevention process with one program in Alaska. Public education on substance abuse was undertaken to increase the pool of knowledgeable and skilled people who would be working on preventing substance abuse. Specifically, the Alaskan efforts emphasized community mobilization and empowerment through volunteer networks to increase knowledge of substance abuse and interventions, community-wide awareness of substance abuse, alcohol and other drug education

for youth, problem solving at the local level, and increased involvement and empowerment of the elders.

Maynard and Twiss (1970) describe a pilot model community mental health program at Pine Ridge, South Dakota. Research was generated on social and environmental conditions that were related to mental health, substance abuse, and other health and behavioral health conditions. They describe the historical, demographic, economic, social, and cultural conditions among the Oglala Lakota (Sioux) at Pine Ridge and analyze their significance for behavioral health. A large part of their concern is related to alcohol and substance abuse. They make a number of suggestions for prevention that concentrate on community-wide structural issues. Maynard and Twiss advocate a major social and economic development program that eliminates dependent poverty through providing culturally approved employment opportunities on the reservation, upgrading the educational system, and fostering leadership through strengthening the authority and dignity of the tribal leadership and tribal council. Similarly, Macedo (1988) provides a primary prevention perspective on whole communities that are "injured" and traumatized by modern forces, particularly alcohol abuse. Macedo emphasizes the concept that these communities must first work through their collective trauma and then begin to develop their own internal interventions. May, Miller, and Wallerstein (1993) describe several steps that are useful in developing appropriate community-based prevention programs: (1) listen, (2) develop a relationship, (3) encourage dialogue, (4) avoid polarization, (5) provide a range of alternatives, and (6) help the community initiate options on its own.

Summary and Conclusion

As a group, American Indians experience many problems that are related to alcohol misuse. Alcohol-involved mortality data are worse for American Indians than overall U.S. averages. The age of first involvement with alcohol is younger, the frequency and amount of drinking is greater, and negative consequences

are more common for American Indian than non-Indian youths. The literature summarized in this chapter shows that programs do exist that are attempting to promote health in the face of the problem of alcohol misuse among American Indians. A theme that carries throughout this literature is that programs that address these issues, and thus the efforts of prevention workers, must take account of American Indian heterogeneity as it is reflected in tribal affiliation, cultural groups, language, and blood quantum. We must also take into consideration the young age composition of the American Indian population and the observation that the majority of American Indian people live off rather than on reservations.

What then are the principles that can be extracted from the material covered in this chapter? First, regarding principles that apply to the way prevention workers carry out their work in American Indian communities, there are several observations of importance. The main points are (1) programs must emerge from the community, (2) prevention workers must demonstrate a commitment to the community, and (3) non-community members need to develop cultural sensitivity.

Developing cultural sensitivity starts by becoming aware of one's own cultural values and then learning about differences relative to other cultures. A key point here is to avoid the urge to attempt to become a member of the community—to become an American Indian. Many jokes are made among American Indians about such people as being members of the *Wanabe Tribe*. Acquiring a deeper level of cultural sensitivity requires spending time in a community. However, entrèe to a community, at least at the program level, requires one to identify and negotiate access with appropriate gatekeepers such as tribal councils or representatives from key agencies. A central point in this negotiation is to demonstrate how the community is going to benefit from the program. The historical distrust of outsiders that is present in many American Indian communities is based at least in part on a history of programs that took more than they gave. This is an extremely sensitive issue in many American Indian communities.

Second, regarding the prevention approaches that are most appropriate in American Indian communities, several principles emerge. Use American Indian persons as staff whenever possible and incorporate cultural concepts within the programs. This latter point comes up over and over again. The challenge is how to do this in a meaningful way when culture varies across American Indian communities. Here the key is to design programs in a way that allows the content to be shaped and molded to fit the local culture. In addition, programs must assist people in their efforts at empowerment (Beauvais & LaBoueff, 1985). Prevention programs can be initiated by outside "experts" working with American Indian leaders, but individuals in the local community must continue the activities (Moran, 1995; OSAP, 1990). This does not mean that programs designed for one American Indian community cannot be transferred to others. It does mean that programs should be made relevant to local norms, values, and conditions through particular, culturally sensitive adaptations (May & Hymbaugh, 1989). A further principle derives from the observation that American Indian people live in two worlds: their American Indian community and the dominant society. Prevention workers should keep the concept of bicultural identity in the forefront and should structure programs in a manner that strengthens participants' ability to identify with and function in both of their worlds.

Always keeping the issue of adaptation to the specific culture in mind, prevention workers should promote a comprehensive community approach to prevention. The goal should be to apply comprehensive strategies and programs to reduce alcohol-related problems among total groups and aggregates of individuals (Beauchamp, 1980). The focus therefore is on communities and particular geographic areas and *not* on individuals. No single type of alcohol abuse prevention should be championed, but rather various programs and approaches should be fit or bound together in a mutually supportive and beneficial manner (May, 1992). Therefore, different levels of prevention dealing with a variety of alcohol-involved behaviors should be used and coordinated (Bloom, 1981; Manson, Tatum, & Dinges, 1982). For example, prevention efforts must have plans for involving and

strengthening the community and family. American Indian families that are strong and well integrated produce children with better indicators of adjustment and in most cases, fewer indicators of deviance (Jensen, Stauss, & Harris, 1977). Finally, all prevention programs, regardless of the focus, must ensure that the level of intervention is adequate and that interventions maintain fidelity across sites (Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995). Without these two conditions, we run the ultimate risk of underserving American Indian communities by not recognizing effective and culturally appropriate programs. The various approaches described in this chapter, then, are not at all mutually exclusive, but can be mutually supportive when orchestrated by a comprehensive community-wide plan and approach.

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3

Worldview, Identity, and Prevention in American Indian Communities

Grace Powless Sage

Today, seven generations later, you turn to us as your own culture is failing. The land you took from us, tricked us out of, is becoming too poisoned to feed you. Your rivers and streams are dying. I wonder, why do you turn to us now? Is it because through it all we never stopped praying? Never stopped beating our drums, dancing and singing songs to the Creator? And that somehow, somehow, you couldn't silence us?

—Sioux Elder, Rosebud Reservation

Abstract

According to 1990 census figures, there is no doubt that the Indian Native population is growing rapidly, the population is a young one, and the population is geographically scattered. American Indians and Alaska Natives continue to experience high rates of unemployment and subsequent poverty. Most American Indian Natives continue to encounter substandard housing,

insufficient health care, and other socioeconomic obstacles that make day-to-day living a constant struggle. In spite of these facts, American Indians and Alaska Natives have shown inspiring internal reserves and strategies for survival. Further, it is abundantly clear that many tribal groups have been successful in managing their resources and increasing the life-enhancing conditions for all members in their tribal communities.

The concepts of cultural context, identity, community, adaptability, resiliency, and perseverance have all been long associated with descriptions of American Indian communities but are often misinterpreted and ill-defined. This chapter presents a framework for understanding the culture context in terms of resiliency and the prevention process as it relates to health, mental health, and alcohol and other drug abuse issues in American Indian Native life. It is a design for a way of thinking and being that points to prevention and healing as they are relevant to the Indian Native communities.

Community, context, culture, healing, journey, path, ceremony, traditions: these words fall short of describing what has been the core of American Indian survival since the beginning. (In the United States, the terms Indian, American Indian, and Native American are considered interchangeable when referring to the aboriginal people of North America. The author will follow this convention.) Even so, these are the words and the language that can convey something of the wisdom and endurance of the Indian Natives. The real convincing, beyond words and language, comes in the day-to-day living and being face to face in a place that is far from that "other" world. It can be a challenge to many with another worldview to distinguish between mental health needs that are signals for intervention and Indian Native cultural distinctiveness that has provided strategies for prevention and survival.

When I first entered the field of psychology, I had no idea of the transformation that would take place for me from my entrance to the academy to my exit. I can only say that I would learn more about the capabilities, endurance, and sheer strength

of the American Indian Native spirit after the completion of my "training" than anything that I had learned or read during my years of formal education. My transformation confused the need for intervention and the cultural distinctiveness of Native people. The theory did not match the reality and it taught me to look at the deficit of the individual, rather than to understand the resiliency of the community.

I would be faced with circumstances and situations that were harmful, strenuous, and inconceivable, and yet here was a person sitting across from me asking for my assistance in helping them to heal. I was dumbfounded by the honest and forthright requests, and at the same time, fully aware of the insufficiency of my suggestions to people who had endured incalculable and unpredictable personal, family, tribal, and community changes. Still, here they were, in my office, asking for my help and assistance with their healing. I would ponder long and hard about their willingness to yield to my offerings with no mistrust in my adequacy. Finally, I was convinced that I was just another thread in a system that throws out life-ropes to many population groups. But the American Indian nations of people are practiced in learning ways of survival.

It was not until after I had been working for a while with many American Indian Natives that I realized that their strength, their wisdom, and their adaptability involved knowing how to survive all those life-rope systems. At the same time, an awareness grew in me that they had been using "prevention" methods long before it became the hot, new catch phrase of the profession and of Federal agencies.

Now, I chuckle at myself to think that I had thought there was something inadequate in my offerings. In fact, some of these American Indian people would say that I was more closely related to spiritual and medicine ways than I would certainly believe. Their acceptance of me as one of them was a humbling learning experience, for they accepted my perspectives as part of a larger system. Some of the more traditional American Indians would be respectful and aware of the need and practice of sharing all ways of healing for all sorts of ills. They would desire to meet all those in the business of healing and make

great efforts to share and embrace new ideas and concepts to ensure the continued well-being of their tribal community. In the American Indian Native community, they would wish to include all aspects of the healing circle and helpers who had specific knowledge or information in the physical, social, psychological, and spiritual ways of healing. This was truly a holistic model of being.

They would think it was silly to isolate one part of a person and only try to heal that part. This total and holistic view has been the practice of many American Indian tribal groups for thousands of years. Their survival has depended on the wisdom of their beliefs in the interrelatedness and connectedness of everything in the world. Further, American Indians have a clear understanding of the need for passing along all the information necessary for the survival of the community and the culture for future generations to preserve and for the prevention of the loss of their identity and well-being.

Prevention has been defined as "an active process of creating conditions and fostering personal attributes that promote the well-being of people" (Lofquist, 1992). Given this definition, one could allege that American Indian Natives have been working in the field of prevention for a long time.

Prevention and the American Indian Native Community

Since there is an awakening in the "other" world of the need, in fact the desire, for new paths to prevention and a new understanding of the connection and relatedness of physical health to mental health to alcohol and other drug misuse and abuse, it might benefit the reader to learn and understand how the field of prevention has developed in the American Indian community. It is a sense of well-being, healing, and a cultural context for which American Indian Natives have a keen awareness. Prevention takes place in their communities and within the cultural context and environment of that community. This is what serves as the connection to the "healthy" paths of the past, the

paths that bring them into the present and show how they must continue into the future. American Indian Natives share that prevention notion among their families, clans, tribal groups, communities, and with many others through their stories, ceremonies, and traditions. Their ways of survival, their ways of mental health and well-being, their understanding of themselves and their communities and their environment, was and is how they practice prevention and healing.

The Ways of Prevention

The Indian Health Service and its health, mental health, and alcohol and other drug treatment policies have been moving away from conventional psychological thought and toward the recognition and maintenance of health and mental health as it is defined and valued in the American Indian community (Nelson, 1988). The view of American Indian mental health must be observed in the cultural context of the American Indian Native communities that have been able to survive despite devastating conditions. What are the strengths, the learning, the ways of prevention, and the forces that lie within an interlocking network of family, clan, society, friends, and community that integrate the individual back into the tribal group?

The prevention and intervention concepts embedded in traditional ceremonies (such as the sweat lodge and other religious ceremonies) reinforce and strengthen the family and community. These healing practices and religious activities have taken place for untold centuries. They have been passed on to medicine men and women in an organized and ritualized way so that these people may serve, not only to treat but also to *prevent* illness of a psychological or physical nature (LaFromboise, Trimble, & Mohatt, 1990). A focus of prevention through these traditional healing ceremonies not only contributes to the healing of the individual and reaffirms the norms of the entire participating Native community, but also continues the training and practice of the traditional healing perspective (Powers, 1982). New solutions, ideas, and creativity evolved within the

ceremonial life of the Native community (Walker, 1980). Prevention and intervention were interrelated to the religious, physical, and psychological environment and the medicine healers were the communicators and connectors to the individual and the community.

The impact and durability of the practice of prevention and intervention by American Indian Natives for thousands of years should engender respect for their enduring spirit. They are stubborn in holding onto what they feel is important and they discard what they do not feel they need—often with community consensus. There is no argument that Indian Native peoples have survived for thousands of years under all kinds of conditions and circumstances. Vine DeLoria (1969) stated it most succinctly in his book *Custer Died for Your Sins:* "They do not fly from fad to fad seeking novelty. That is what makes them Indian."

What is important to understand about the American Indian Native is their organization, community, networking, and sense of tribal purpose and solidarity. What is important to understand about the Indian Native is their connectedness and sense of place and land. The driving force behind prevention and intervention practices common in American Indian Native communities include holistic healing, community, and relatedness of all living things in the world. This strong sense of survival despite repeated governmental policies of extermination and genocide, and vast differences between and within tribal groups, makes the most persuasive argument for the efficacy of prevention as practiced by Indian Natives.

It is not difficult for most people to understand the practice of prevention when discussing strategies such as the sweat lodge ceremony or the religious ceremonies of the Indian Native as preventive in nature. What is more complex and involved is understanding how healing can be seen as a prevention strategy, particularly in situations related to alcohol and other drug abuse. The relationship between healing and prevention might make more sense if the healing ceremonies were to take place in the context of a culturally integrated community, and there was a sustained approach that targeted and involved the total community system for the identified purpose of healing and prevention.

After all, the healing ceremony would be comprehensive, target multiple systems, and use many healers and strategies—this has been defined as community-wide prevention (Benard, 1988).

The Ways of Healing

American Indian Native communities have long since mastered the art of community healing. The traditional healers understand and recognize the need for assistance when community-based healing is unavailable and when additional systems are needed. All resources, then, are seen as useful, complementary, and beneficial. Traditional healers do not separate the culture from the context and view the connection and dynamic interaction between them as necessary for the healing process. Primeaux (1977) writes that traditional medicine and healers embrace a wide array of energies that are interwoven into all aspects of being. The healers are frequently viewed as the connectors and preservers of the history, stories, and ceremonies necessary to maintain the cultural values and the context within which the cultural values flourish.

Individual healing ceremonies and prayers are seen as a means of accomplishing community solidarity and affiliation. These community connections also facilitate the creation of and possibilities for new solutions and new ways of dealing with old problems and conflicts. The healing and the healer support the cultural context through the ceremonies and stories and help to treat the individual and also to reaffirm the norms of the entire group. Prevention work is a result of the interaction between the healer and the client involving family, tribal, and community members who also benefit from the exchange between the individual, the group, and the sociocultural environment.

There are many systems of healing among American Indian Natives. Nearly all of them share the belief that large communal ceremonies serve as a way of promoting the well-being of the entire tribal group. This total and holistic view of healing has been the practical application of prevention methods for both naturally caused illnesses (e.g., disease, broken bones) and

illnesses of the mind and spirit. Indian Native prevention work is concerned primarily with the benefits to the emotional, spiritual, psychological, and cultural aspects of the tribal group. Thus, the role of the healer, as traditional practitioner, is one who reaffirms the cultural values, integrates all the pieces into the cultural context, and considers all those involved in the community.

The non-America Indian concepts of personal insight, individual awareness, and self-actualization are seen as agents of separation between the American Indian Native and their world. This separation between self and other can be problematic and dysfunctional to the Indian Native experience and worldview. Trying to balance the two systems of mental health and Native health, both conceptually or through application, can create multifaceted problems and can be programmatically very difficult to implement. The implementation may come in the form of realization or creation of a model for the practitioners who recognize the role they serve in the healing process with American Indian Natives. The awareness that one is part of an entire traditional healing process that has an established history, practice, credibility, and acceptance can be crucial and effective to the practitioner's survival, and more importantly, to the healing itself. Thus, with a new model, the practitioners become part of the circle of healing and foster a relationship with the rest of the healers in the circle in order to understand the roles and services of each. The outcome of this model would be that American Indians, who live in multiple and complex communities, would be able to find sustenance and healing regardless of the setting (Moses & Wilson, 1985). Moreover, the process and development of the model has yielded new disciples of healing and prevention, who then go on to become the new healers and traditional practitioners of the future.

Ceremony, Healing, and Prevention

Prevention is often discussed in terms of strategies and efforts. Keeping in mind the purpose of healing and the purpose of prevention, it might be useful to combine the two as they do inter-

act and relate in American Indian communities with respect to alcohol and other drugs.

The prevention strategy of information dissemination provides awareness and general knowledge regarding alcohol and other drug use, abuse, and addiction. Most of the time, this strategy is often one-way communication with infrequent contact. In the American Indian Native community, information dissemination involves many individuals (the community healers and practitioners) meeting together (in ceremony) for the purpose of involving and making aware (healing) as many community members as possible (prevention).

Education strategies of prevention regarding alcohol and other drugs often involve two-way communication and distinguish themselves from information dissemination by the fact that interaction occurs between the facilitators and participants. Typically, the education also impacts skill development and abilities. In the American Indian community, education regarding alcohol and other drugs (prevention) often appears as part of the individual and community participation (healing) in the ceremony. The skills and abilities would be the community's solutions, new ideas, and creativity to address problems regarding alcohol and other drugs. Again, the involvement of everyone and everything in a collaborative and cooperative manner for the benefit of the community is a prevention mechanism that supersedes the individual and affirms the cultural context (Trimble, 1982).

Alternative prevention strategies assume that it will be effective to find other constructive activities and ways to minimize the desire to resort to alcohol and other drugs. Programs often develop dances, games, and other optional activities for the sake of creating more viable pastimes. In American Indian Native communities, there has been a widespread awareness and an increased desire to resume cultural practices. This has inspired traditional community, practitioners, and kinship networks to become more supportive and more accomplished at providing cultural services. As these systems have developed, more traditional roles, alternative practices, and ceremonies become more regularly scheduled and systematically available. The result is

that the prevention strategy of healthy and constructive alternative activities is established in the Indian Native community through revitalizing old practices and making the community aware of them.

Problem identification and referral is used as a prevention strategy for individuals who have indulged in alcohol and other drug behaviors, but are not yet abusing or addicted. Common thinking is that the person's behavior can be reversed through education and other activities. In the American Indian Native community, a family will often identify someone who has problems with alcohol and other drugs and whom they feel has the potential to benefit from a ceremony (healing). The same family will also involve others who might be involved with alcohol and other drugs, but are not yet experiencing problems. The public might also be made aware of the time and place of the ceremony for the purpose of involving the community. The result is that identification and referral of an individual, who can often be lost in a system, becomes the focus of the communal ceremony, which involves both healing and prevention.

Community-based process is a prevention strategy that strengthens the community services and agencies to provide better prevention and treatment for alcohol and other drug problems. The process supports the organization and planning for improved collaboration, coalition building, and networking within and between communities. Environmental prevention strategies often relate to legal standards and codes, as well as service-oriented initiatives developed in complement with societal changes and practices. In Indian Native communities, the healing and prevention efforts by a multifaceted and multitalented group of people established this community-based process as the foundation for their understanding and worldview. Historically, Natives have instituted intertribal linkages for the sake of survival and development. Soon these linkages became reinforced through the commitment and caring of the healers and traditional practitioners. As the bonds of relatedness grew stronger, stories and ceremonies were revived to champion the natural process that was nearly eradicated by the Federal Government and its systematic policies of termination

and extermination. Many of the activities that take place in Indian Native communities today result in the improvement and maintenance of many of these communal practices.

Inouye (1993) has proposed four strategies to be included as prevention and intervention approaches when serving the mental health needs of American Indian adolescents. These methods can be broadened to include the Native Indian context and community. The strategies include: (1) strengthening and building on family ties that are a source of spiritual and cultural pride; (2) identifying sources of depression that stress the community and enhance traditional ceremony; (3) augmenting American Indian Native community practices that enhance worldview and identity through the use of ceremony and tradition; and (4) involving the entire community in formulating healthy prevention projects to ensure survivability and sustainability.

While American Indian Native communities still struggle with alcohol and other drug problems, flexibility and adaptability at all levels have been the standards and practice for centuries. Often the versatility in the individual and the community came about in response to dwindling resources, unexpected crises, and changes as implemented by governmental agencies. The hallmark of the Indian Native spirit has been their community values and spirit, permanence, patience, and sense of humor during periods of great dissonance and necessity. The environmental practices of ceremony, prevention, and healing embedded in the entire fabric of Indian Native life have withstood the test of durability.

Conclusion

The recent attention to cultural competence and prevention as it relates to substance abuse is refreshing and exhilarating. What is unsettled in my mind is the nature and direction of cultural competence and prevention efforts. Basically, the field of prevention can be considered to be in a vacuum in the academy or the bureau or the agency charged with prevention and intervention responsibilities. The real accomplishment of cultural

competence and prevention will be in day-to-day real life circumstances. When an American Indian Native can seek ceremony, healing, and prevention in response to a distress they are experiencing and the help-givers, healers, and significant others converge to blend elements of the existing treatment approaches to the benefit of the distressed Indian Native, then the concepts of prevention and cultural competence become real.

The result of that convergence of tradition with the contemporary is that Indian Natives return to their previous and customary sociocultural role within their own cultural context. The circle is complete and revitalized due to the fact that healing and prevention have again served the role that Indian Native culture has believed in and practiced for a long time.

In this chapter, cultural competence has been defined as recognition of the relationship between the American Indian Native groups and the concepts of healing and prevention. It has been argued that the Indian Native values of community, ceremony, healing, and prevention do not always follow contemporary health or mental health practices. In fact, the Native conceptual notions of healing and prevention are often at odds with a non-Indian approach to services and service delivery.

What is important to remember is that once culturally valued services and programs are embedded in the cultural context, the role of holistic healing, ceremony, and prevention can only be viewed in that context. Then services and practitioners adjust to one another in order to form an entire program, which is supported and meaningful in the cultural context. Taken out of context, as is often the case, the value and practice of healing and prevention in the community with cultural competence can be seen as unnecessary and impractical.

Those who come from different cultures and understandings have dominated the traditional models for healing and prevention. The pressing need for cultural competence at all levels of training, service, and service delivery is evident. The assumption that current training strategies, program manuals and text, and levels of competence with regard to cross-cultural skills and knowledge are sufficient is arguable. Often, the meager amount

of coverage and information that clinicians and educators receive is stereotyped, outdated, and inaccurate.

If training programs for mental health, physical health, and substance abuse programs are genuinely intent about integrating the sociocultural environment, then it is imperative that they begin to define community, prevention, networking, collaboration, and healing as it relates to cultural understanding and awareness. They must refine the treatment process to incorporate all the elements of healing and prevention, and include others in the cultural context and community to offer appropriate interpretations and analyses. Ideally, the process will be ever-expanding and inclusive of the role of culture, context, community, and competence. The outcome of this kind of process can lead to the development of new sociocultural theories, understandings, and models.

As prevention and healing have advanced in the Indian Native communities, it is becoming clear that the collaborative efforts of many in the circle are helping to reduce the problem behaviors of alcohol and other drug problems. All people involved in prevention efforts should support and nurture the developments that work and encourage further exploration.

For many people of all cultures, when an individual has a problem, that individual needs to be responsible for the solution. Likewise, when problems like alcohol and other drug abuse are grounded in the community, then let us listen to the community for resolution. It is incumbent on the practitioners to seek to discover and understand the culture of the American Indian Native. Moreover, it is imperative that we support the existing Native practices and nature of healing and prevention. It is important to understand our role and discover the need for fitting into present models. The integration of traditional healing practices with contemporary healers can create a blend of realistic and culturally congruent services.

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4

Prevention in Alaska: Issues and Innovations

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Abstract

Diversity of geography, climate, and culture dictate the nature of the service delivery systems in Alaska, including the provision of drug prevention programming. Described here are training programs, conferences and symposia, health fairs, and culturally derived interventions that meet the diverse needs of the native people of Alaska. These interventions operate at the State, local, and regional level with a great deal of attention paid to cooperative and synergistic efforts. Many years of experience with these various programs have led to a body of knowledge or "learnings" that will inform the maintenance of current prevention activities and the development of future efforts.

As diverse as the land, so are Alaska Native people. Culturally, there are at least four Eskimo language groups (e.g., Yup'ik, Siberian Yup'ik, Cup'ik, and Inupiat); numerous Athabascan linguistic groups with varying dialects (e.g., Gwich'in,

Koyukuk); the Aleut and Alutiq people; and the southeastern Tlingit, Haida, and Tsimshian groups. Within each region there also exists non-Alaska Native populations including Euro-Americans, Latino Americans, Asian Americans, and African Americans. The percentages vary from area to area but in the numerous small villages the vast majority of residents are Alaska Native.

The geography of Alaska presents logistical and diversity challenges not only for the communities themselves but also for human services delivery. Alaska is a vast area with a population of indigenous and rural people scattered over a geographic area one-third the size of the continental United States. There are approximately 1.07 square miles for each person in Alaska (New York has 0.003 square miles per person). The State encompasses 586,412 square miles and 6,640 miles of coastline and contains four major mountain chains and more than 3,000 rivers (Thompson & Smith, 1991). The rugged terrain, of which about one-quarter is above the Arctic Circle, is buffeted by extreme variations in climate, ranging from average temperatures in January of –14ºF in Barrow to 15ºF in Anchorage and 34ºF in the southeast (e.g., Ketchikan). Daylight hours also vary, the most extreme example being Barrow—which experiences 84 continuous days of sunlight during the summer months and absolutely no sunlight for 64 days during the winter.

Although little more than half of the more than 550,000 people who live in Alaska live in one of the three cities (i.e., Anchorage, Fairbanks, and Juneau), many people live in small, geographically dispersed, rural communities (Thompson & Smith, 1991). The more than 200 villages range in population size from 10 to 700 or more people, interspersed with regional centers of 1,000 to 5,000 people. Transportation in Alaska, due to limited road systems, is largely restricted to airplanes and boats, and snow machines and dog sleds in the winter. Traveling by plane is extremely expensive (it generally costs more to fly in-state than out of the state) and highly unpredictable because of weather fluctuations. Prevention efforts, mental health service, health care, and alcohol and substance abuse treatment delivery become an immense challenge in this environment. Rural areas

can not support health care professionals and mental health providers in each small village. Given the variable weather and distances from cities and regional centers to villages, itinerant professionals are hard pressed to serve the health and mental health needs of such a dispersed rural people.

A focus on diversity, isolation, and the rural nature of Alaska allows one to see the challenges of service delivery. Many Natives call rural villages home. Although nearly one-quarter of Alaska's Native population lives in Anchorage and Fairbanks, the majority are born and raised in villages, have strong ancestral connections to the village and surrounding areas, and carry a fierce pride and loyalty to their home village. Any intervention or planned prevention effort must consider the strengths of these villages and focus on building the community as a whole.

People who leave the village often return periodically or permanently. The village identifies the person. The family name is part of village history. When people introduce themselves through their family lineage, one hears over and over the names of villages joined by marriage and the repetition of the home village's name. As one enters a village, one hears of the pride of place; the accomplishments of the people; the success of the hunt for whale, caribou, or moose; the success of the basketball team; the knowledge of and respect for the elders; and how the village shapes modern life. The taste of traditional foods, the aromas while they cook, and the other smells of the village are missed when a person is gone for even a brief period. People who enter a traditional camp setting for recovery from alcohol abuse comment on how important the traditional foods and rhythm of life are for their recovery. Village life simply moves at a different pace. It is not slow or fast that best describes it; it is a pace built over generations that recognizes the physical and demographic realities of who lives there and what must be done. Waiting and patience are words often used. Perhaps they fit and perhaps they don't. Perhaps the better descriptors are being at peace in the present and preparedness. However one describes the life of a village in rural Alaska, there are unique features that make it that village and no other.

It is the understanding of this unique place and its people that is so critical to prevention efforts. Local control and origination of projects based upon locally articulated needs and strengths are critical to prevention strategies that are empowerment-oriented. What is so crucial is a deep respect for each village as a place where people grow and are nurtured. It is a place where problems exist, but the problems can only be understood and eradicated if the strengths, the positive nature, and the potential of the village and its people are understood and incorporated into prevention efforts.

Communities throughout rural Alaska are creating community-based treatment and prevention methods, as well as using existing indigenous cultural resources to treat and prevent health problems and alcohol and substance abuse (Jennings, Baker, Riggan, & Aubrey, 1993). Further, *People In Peril* (*Anchorage Daily News*, 1988) described a growing revolution of hope known as the Alaska Federation of Natives (AFN), Inc. Sobriety Movement. The sobriety movement stresses the need for people of the villages, not health agencies and corporations, to take responsibility for their own well-being. Yet alcohol is just one of the health problems Alaska Native people face. Beginning with measures to control and eradicate tuberculosis in Alaska Native villages, which has been a major accomplishment, other health problems, particularly rising concerns about behavioral health risk factors, have received a great deal of current attention because they account for the major causes of mortality. A concern about how to prevent health and behavioral health problems in Alaska has focused increasingly on building personal and community competence in order to increase hope among Alaska Native communities.

Alaska's Need for Preventative Health Programs

What is killing Native residents of Alaska? The answer has changed dramatically over the past 50 years. Before the advent of mass vaccination and widespread availability of antibiotics in

rural Alaska, the leading killer was infectious diseases. In 1950, infectious disease was the leading cause of death, responsible for 45.8 percent of deaths among Alaska Native people (Middaugh et al., 1991). In contrast, the current causes of death among Alaskan Native people are more likely to be related to behavioral health risk factors (Alaska Natives Commission [ANC], 1994). The leading cause of death between 1980 and 1989 was unintentional injuries (22 percent), which included drowning, aircraft and motor vehicle accidents, fires, and injuries related to alcohol and other drug abuse (Middaugh et al., 1991). Heart disease (16 percent), cancer (16 percent), suicide and homicide (11 percent), respiratory problems (6 percent), and congenital diseases (4 percent) followed as the second through seventh leading causes of death. These are variously related to behavioral risk factors including smoking, diet, lack of exercise, stress, alcohol abuse, and drug misuse.

Alcohol abuse is ranked first among behavioral health risk factors in Alaska. In 1994 and more recently, Alaska ranked third among the states in per capita consumption of alcohol (Landen, 1996). According to data from the Behavioral Risk Factor Surveillance System (BRFSS), 22 percent of Alaskans are binge drinkers (Hickle, Lowe, Clarke, Streuber, & Whistler, 1994). Alaska ranks second in binge drinking among the 48 states surveyed in the BRFSS. As many as 45,000 Alaskans are estimated to be problem drinkers.

> *Up to 25% of all deaths in Alaska are alcohol or drug related; alcohol is involved in one-third of fatal motor vehicle crashes; nearly 50% of child abuse and juvenile crime is related to substance abuse; alcohol has been linked to up to 72% of suicides among Alaska Native males 15–24 years of age—a group with a suicide rate up to 14 times the national rate. (Hickle et al., p. 71)*

Further, of the 801 deaths attributable to alcohol between 1992 and 1994, 36 percent were Alaska Natives, although Alaska Native people represent only 17 percent of the State's population (Landen, 1996). In Anchorage, Alaska's largest city, where 5.1 percent of the population are Alaska Native, Native people

accounted for 27 percent of those treated for alcohol abuse, 22 percent of all violent deaths, and 49 percent of all fatal accidents in a 9-month period (*Anchorage Daily News*, 1988).

Alaska's reported rate of fetal alcohol syndrome (FAS) is four times the U.S. average (Hickle et al., 1994). FAS estimates among Alaska Native populations are 5.1 per 1,000 live births compared with 2.2 in North America (Lally, Schubert, Faure, & Parker, 1995). The Alaska Native Public Health Service reported 73 percent of women who had given birth to an FAS child reported being sexually abused as a child. Their data indicate that sexual abuse often occurs simultaneously with alcohol abuse. The ANC (1994) reported alcohol abuse as a significant contributor to the breakdown of family and community life.

Further, suicide rates indicate that on average during the 1980s, a death from suicide of an Alaska Native occurred once every 10 days (ANC, 1994). Research by Hlady and Middaugh (as reported by Kettl & Bixler, 1993) found that 79 percent of Alaska Native suicides (1983–1984) had detectable levels of alcohol in their blood. A review of death certificates and corresponding Indian Health Service records by Kettl and Bixler (1993) indicated that alcohol abuse was diagnosed more often than any other psychiatric disorder for Alaska Natives who had committed suicide between 1980 and 1984.

These statistics demonstrate that alcohol abuse constitutes a public health problem of immense proportions for Alaska Natives. The Alaska Federation of Natives (AFN) report *A Call for Action* (1989) called alcohol abuse "the latest epidemic" to hit Alaska Natives. More recently, the ANC (1994) wrote the following:

> *As evidenced by both the statistics and the volumes of first-person testimonials given to the Commission by Natives, alcohol abuse among Alaska Natives is a culprit that, if unchecked, holds the very real potential for permanently destroying the social, cultural, physical and emotional well-being of Natives as a people. (p. 69)*

Alaska Natives are not alone with respect to alcohol-related problems. Research has shown that Arctic areas generally have

a greater problem than more southern areas, leading researchers to look for genetic causes (Hild, 1987). For example, research with Alaskan and Siberian Natives (Segal, Duffy, Avksentyuk, & Thomasson, 1993) suggested that Alaska Natives eliminate alcohol faster than Euro-Americans and do not possess the atypical genotype found in 50 percent of Asians that serves as a protective factor. Further, historical analyses (Duran & Duran, 1995; Napoleon, 1991; Rose, 1995) point to rapid acculturation and missionary actions as factors in Native alcohol abuse. Generations of Alaskan Native people were removed from their families and sent out to boarding schools, many against their will, which broke down communication between young and old as well as breaking down a sense of Native culture (Charles, 1991; Marum, 1988; Napoleon, 1991; Rose, 1995).

Among infectious diseases, the newest threat to Native lives, as well as all other Alaskans, is HIV/AIDS. Nationally, as of 1995, HIV infection was the leading cause of death for men aged 25–44 and was the third leading cause of death for women in that age group (Centers for Disease Control and Prevention [CDC], 1995). Additionally, while men who have sex with men still make up the largest percentage of AIDS cases, the largest growing segment is due to heterosexual contact. In 1996, 50 percent of AIDS cases in the Nation were men who have sex with men (CDC, 1996), but in Alaska, this risk group made up 57 percent of the total AIDS cases (Alaska Department of Health and Social Services [ADHSS], 1996a). Nationally, 26 percent of AIDS cases are injecting drug users (CDC, 1996), while in Alaska, this group comprises 12 percent of the total number of cases (ADHSS, 1996a).

Between 1982 and 1996, 369 Alaskans were reported to have AIDS (ADHSS, 1997) of which 194 are known to have died, leaving 175 people living with AIDS (PWA) in Alaska. Alaska's 1996 annual rate of AIDS for adult and adolescent males was 11.4 per 100,000, which is below the national average of 51.9 per 100,000 (CDC, 1996). Between 1990 and 1996, an average of 39 new cases of AIDS each year have been diagnosed (ADHHS, 1997). Further, 17 percent of the total number of known AIDS cases in Alaska are in Native American or Alaska Native people

(ADHHS, 1996a). According to testing data, Alaska Natives represented 16 percent of the 590 HIV-positive cases (ADHHS, 1996b). However, these data need to be viewed with caution. Although AIDS is a reportable disease in Alaska, HIV infection without AIDS is not. Consequently, it is more difficult, if not impossible, to get a true measure of the overall HIV infection burden on Alaska's population. Further, determining the infection rates for rural Alaska is even more difficult. People from rural Alaska often come to large urban centers such as Fairbanks and Anchorage to be tested, and are subsequently counted in the numbers for those cities. Additionally, upon diagnosis many people move from the rural setting to urban areas (Bonnie McCorquodale, personal communication, July 1997). Most important, a great number of at-risk people in rural Alaska are not being tested. As a result, there is a real need for HIV/AIDS education, prevention, and screening programs throughout rural Alaska. However, even if testing were readily available in rural Alaska, it is reasonable to expect, considering the amount of social stigma still attached to HIV/AIDS, that it would be used infrequently in such a small, closely tied setting.

As difficult and challenging as the task of prevention may seem given these statistics, it is critical to consider them in the context of the enduring and ancient commitment of Native people to the land and their villages. Because the major killers of Alaska Native people are related to behaviors, there is a great deal that can be done to intervene and reduce further loss of lives. An incredible opportunity to make a difference in the health and vitality of people living in rural Alaska exists. Hearing this call, many organizations from a Federal and State level to individual villages are responding and preventative health programs can be seen throughout Alaska.

Meeting the Challenge

Training for Health Promotion and Prevention

Rural Community Health Aide Program

The challenge of providing ongoing primary health care as well as health promotion in villages was addressed in the 1950s by rural community health aides, which resulted in the creation of Alaska's unique rural Community Health Aide Program (CHAP) in 1987. The goal of the program is to have a trained health provider in each village with a commitment to utilizing local people. CHAP thereby builds the capacity of villages to deal with their primary health care needs. The Community Health Aide (CHA) is educated over a 1- to 2-year period of intense classroom and clinical experiences. The students attend four seminars of variable length taught by faculty who are physician assistants, nurses, or physicians. Once completed, the CHA is supervised and supported by health care professionals in regional centers through telephone consultation and periodic visits. After 1 year of training students receive a certificate, and after completing a 64-credit-hour program, they receive an Associates degree from the University of Alaska (Mohatt & Salzman, 1995). The CHAs are employed by regional Native nonprofit corporations or other tribal contractors. Most if not all Alaskan villages have one or more CHAs who now provide most of the primary health care for rural villages:

> *The CHAs have become an indispensable, important component of health care for rural Alaska Natives. The CHAs ensure that basic primary care services are available, accessible, continuous, acceptable to the population and cost effective. (Alaska Native Health Board [ANHB], as cited by the ANC, 1994, p. 49)*

Rural Human Services Certificate Program

Recognizing the growing need for rural community-based mental health and prevention services, the CHAP model of service delivery and training was adapted to train village-based mental health and prevention para-professionals. The Rural Human Services Certificate Program (RHSCP) offers training to rural human services providers through the College of Rural Alaska at the University of Alaska Fairbanks. The program was developed over a 2-year period through a cooperative effort between the State of Alaska's Office of Mental Health, staff and faculty of the University of Alaska, and a statewide group of Alaska Native people (Mohatt & Salzman, 1995).

The planning group met over a 2-year period to identify what a village-based mental health worker should know in order to work in prevention and service roles in Native communities and how they should be taught. They focused on identifying Alaska Native knowledge bases and Western-based knowledge bases (e.g., counseling approaches with a family and grief focus) that could be adapted in order to be compatible with Native knowledge. The university faculty facilitated the group, structured their work into a curriculum, and had it reviewed a number of times by the statewide council. In 1991, RHSCP became a certificate program at the University. The most central innovation of this program and what makes it unique is that it is an Alaska Native model for education based on integration of Native values and knowledge with Western values and principles that serve to facilitate individual, family, and community healing. The philosophy of the program emphasizes building strengths and wellness of individuals, families, and communities through balance with one's physical, social, and spiritual environments. The philosophy also stresses that effective health service delivery requires healthy and effective providers, thus character development and growth in wellness is integral to the learning of techniques (ANHB, 1994).

Students participate in four 3-week sessions, each week covering a different topic, such as Alaska Native family systems, cross-cultural bridging skills, traditional native counseling,

process of community change, and understanding addictive processes. Students move through the program as a cohort. They meet two times a year, taking different courses each time. Upon returning to the village they complete homework assignments and engage in practice. Faculty for the seminars include elders, practitioners, and university faculty with significant experience in rural settings, and guest speakers with specific areas of expertise.

The students work closely together and form a strong bond and identification with the program and the group. They spend many hours in informal group and individual support and "natural counseling" with each other. Classes integrate content with personal development so that knowledge, personal growth, emotion and intellect, individual and group, catharsis and control, all occur in a supportive, community or family-like, environment. This is fundamentally an interconnected model analogous to kinship. It is one in which relationships between people and between knowledge domains is accentuated. As a result it looks and feels very different from conventional university training. The unique curriculum and approach reflects the expertise of Native people from all levels of the Native community (ANHB, 1994). It is this unique blend that has been characterized by a Yup'ik member of the Rural Human Services Council as "your setting being adapted to our model." Students take back to their villages a process of how people can grow and change through a truly healing community. Personal growth, skills training, cultural revitalization, and community building create the basis for education as a transformative process.

In a recent evaluation of the program (Donahue, 1997) participants revealed that the presence of elders was critical to the impact and the quality of the culturally based curriculum. There is a paucity of literature on how best to work with the elder "wisdom keepers" and RHSCP is undoubtedly breaking new ground in this area. It is clear from the participants that elders become identification models, provide specific advice and emotional support, and assist in articulating how one can approach counseling or other forms of intervention and prevention from a Native perspective. Elders speak of the knowledge of how to

solve and prevent problems and how to understand human problems, and of the ways of treatment that have been used for generations. Wisdom then becomes a living, oral knowledge applied to current contexts.

Further, the RHSCP provides a bridge between the rural workplace and the university system. The RHSCP has developed an entry-level 30-credit curriculum of 100 and 200 level courses leading to a Certificate degree that offers a 2-year Associate of Applied Science degree in Human Service Technology (HST). In turn, the HST degree is offered by the University's School of Social Work. In October 1993, the first training cycle was completed. At this time, there have been 29 Certificate graduates and one Associate's degree graduate and there are more than 50 individuals currently in the program.

In addition to formal training programs such as CHAP and RHSCP, at least two annual statewide conferences, the Prevention Symposium and the Rural Providers Conference, provide opportunities for people working in prevention to gather, share ideas, and learn from a variety of leaders and experts in the field.

The Alaska Council and the Prevention Symposium

The Alaska Council on Prevention of Alcohol and Drug Abuse with the aid of numerous local and statewide sponsors (including the State Division of Alcoholism and Drug Abuse) has hosted an Annual Statewide Alcohol and Drug Abuse Prevention Symposium since 1981. The Symposium is generally held in November in Anchorage and attracts 650–700 participants, 60 percent coming from rural Alaska (Tim McGrath, personal communication, May 1997). Alaska Native people are integral to the planning and success of this conference. A Healing Day Ceremony traditionally kicks off the conference with traditional Native ceremonies, drumming, and dance, encouraging communication among people of diverse backgrounds. In addition, Alaska Native people organize and present many of the conference sessions. Topics in the past have included *Village-based Prevention Strategies, What is Community Development*, and *Healing the Wounded Spirit*. The Prevention Symposium attracts

people from all walks of life, including parents, teachers, social workers, prevention specialists, treatment providers, village leaders, and youth. More than 150 youth attend and participate in an activity and presentation tract at the Symposium designed especially for them and for people who work with youth. As an indication of the importance placed on youth involvement, at the 1996 Symposium, a youth provided the first ever youth keynote address.

The Alaska Council, which organizes the annual Prevention Symposium, is a statewide prevention agency dedicated to reducing and eliminating the devastating effects of alcohol, tobacco, inhalants, and other drugs. The Council provides referral services for agencies and has one of the largest specialized, culturally relevant libraries (including books, pamphlets, videos, and school curricula kits) on topics ranging from traditional healing to parenting, substance abuse prevention, healthy choices, self-esteem building, and community building. In addition, the Council has three specialists who travel throughout the State spreading the prevention message, providing specific technical assistance to communities, and keeping current on the pulse of substance abuse in Alaska (Tim McGrath, personal communication, May 1997).

Rural Alaska Community Action Program and the Rural Providers Conference

Since 1965, the Rural Alaska Community Action Program, more commonly known as RurAL CAP, has encouraged efforts of villagers attempting to break the cycle of dependency and gain control of the changes affecting their lives. RurAL CAP works side by side with people in communities throughout the state to develop strategies which will work at the local level and has been involved with the AFN Sobriety Movement since its inception (ANHB, 1994). RurAL CAP is a private, nonprofit corporation whose mission is to protect and improve the quality of life for rural Alaskans through education, training, direct services, advocacy, and strengthening rural people's ability to advocate for themselves. Service and technical assistance programs are directed at child development (such as Head Start and Parent-

Child programs), protection of subsistence and advocacy on behalf of natural resources needed to support a subsistence economy, alcohol and drug abuse prevention, and energy and weatherization projects (RurAL CAP, 1994).

Beginning in the 1970s, in order to address Alaska's need for village-based alcohol and substance abuse services, RurAL CAP sponsored a counselor training program, which eventually evolved into independent programs sponsored by regional health corporations. To assist local efforts, RurAL CAP maintains a statewide network of mutual support through teleconferences, an extensive library and resource center of information and reference materials, and a monthly newsletter. RurAL CAP also provides two manuals, *Nation Building* and *Paths of Discovery*, designed to support the AFN Sobriety Movement. The manuals serve as personal and community empowerment guides for people working in rural Alaska. Additionally, the Alcohol Prevention Program provides specific support and technical assistance through Beginning Alcohol and Addictions Basic Education Studies (BABES) and an FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) Training Specialist. BABES is a primary prevention program that uses puppets to help children develop positive living skills and provide them with information that enables them to make healthy choices about alcohol and other substances (ANHB, 1994).

Since 1984, RurAL CAP has been the driving force behind the annual Rural Providers Conference (RPC). The RPC draws over 300 village-based providers of substance abuse prevention and intervention services around the state, and in recent years the conference has grown to include family members and other participants who come to learn new skills and celebrate their own sobriety. The RPC is planned and facilitated by conference participants, with logistical support from RurAL CAP, co-sponsoring organizations, and the host communities. The conference has been primarily hosted by rural communities, including Soldotna, Nenana, Glen Allen, and Bethel in 1995–96 and Sitka in 1997–98.

Over the years, the conference has grown in both size and sophistication, with well-known speakers and workshops cov-

ering a vast array of technical areas. Yet it still holds firm to its original goal of providing a forum through which rural providers can share information and ideas in a culturally relevant manner (ANHB, 1994, p. 23).

Workshop sessions covering topics such as suicide prevention, inhalant abuse, Native spirituality, and traditional storytelling provide an opportunity for participants to learn about new and traditional approaches to community-based prevention programs to combat alcohol and drug abuse. Evening events such as a potlatch dinner, fiddle dancing, and a cultural sharing night provide opportunities for participants to renew energy and connect with service providers from other parts of Alaska. The conference closes with a Staking Ceremony, a tradition borrowed from the Lakota Sioux and adapted so that participants may honor and symbolize their personal commitment to not back away from the fight against the use and abuse of alcohol (ANHB, 1994).

Statewide Education and Prevention Efforts

AFN Sobriety Movement

The AFN Sobriety Movement is a collective effort on the part of individuals, families, and communities affected by, concerned with, and working toward the prevention of alcohol and drug abuse. It is primarily a campaign whose mission is to encourage and support grass roots efforts to achieve sobriety. Similar to Alkali Lake in northern British Colombia, where community-wide change began with one couple and led to a collective effort and a sober Native community (Guillory, Willie, & Duran, 1988; Johnson & Johnson, 1993), the AFN Sobriety Movement in Alaska began with individuals coming together to help each other. The presentations and the film *The Honour of All* from this community helped to inspire many Alaska Natives to initiate their own community-based process for achieving sobriety (*Anchorage Daily News*, 1988).

The goals of the Movement include encouraging and supporting alcohol-free and drug-free Native families, the practice

of traditional Native values and activities, cooperation with existing groups working to promote sobriety among Alaska's Natives, the formation of sobriety groups in every Alaska Native community, and encouragement and support of sober Alaska Native leaders and role models. One of the activities sponsored by the Movement includes a sobriety pledge drive that helps generate awareness, attract attention to, and encourage participation in sobriety as well as providing a numerical census of who leads, believes in, and supports a sober lifestyle. Each year at the AFN Convention and at other gatherings around the State, members of the Sobriety Movement distribute buttons with the motto "Our Spirit, Strong and Sober" to all those who make a pledge to sobriety. Red ribbons attached to the buttons proclaim "Let it Begin with Me" (ANHB, 1994).

Sobriety Movement members can be seen all around the State, traveling to conferences and gatherings and encouraging people to join the Sobriety Movement and to live the life of sobriety, described as "a positive, healthy and productive way of life, free from the devastating effects of alcohol and drugs" (ANHB, 1994, p. 22).

Another activity is the "Iditapledge for Sobriety" in which pledge signatures are put on microfilm and given to a drug-free Alaska Native dog sled musher, who in ceremonial fashion carries the microfilm in the 1,049-mile Iditarod Dog Sled Race. The race is run annually from Anchorage to Nome in commemoration of the dog team relay that carried vital serum needed to cure the diphtheria epidemic in 1925. Symbolically, the sobriety pledge signatures represent a "serum of commitment" needed to cure the pervasive and devastating effects of alcohol and drugs. In 1994, "musher for sobriety" Mike Williams carried more than 10,000 signatures (ANHB, 1994).

The Movement consists not only of thousands of individuals who have pledged themselves to a life of sobriety, but also more than 50 Charter Groups who have passed resolutions adopting the concepts and goals of the Movement. The movement has been recognized as a model for circumpolar indigenous communities and an effort is currently under way to bring these communities together to share their experiences and knowledge

regarding sobriety efforts (Jim LaBelle, personal communication, May 1977).

The Alaska Health Fair Program

Alaska Health Fair (AHF) is a nonprofit organization whose primary goal is to increase health awareness throughout the State of Alaska and to provide a financially feasible way to deliver primary prevention services to all Alaskan residents (AHF, 1996). The organization provides support and training for communities to plan and stage local health fairs to educate people about various health care concerns through a hands-on approach that includes posters, brochures, multimedia displays, models, screening tests, and counseling. Many of the displays are interactive and fun.

Each year, AHF provides training and technical assistance to community members who want to become health fair coordinators. Coordinator training sessions are held in alternating years in Juneau and Fairbanks or Anchorage and last 2 1/2 days. Training topics range from volunteer coordination and financing to the specific demonstration stations available, choosing a site in the local community, and publicity. The training also includes a demonstration health fair to show participants what health fairs look like and how they run. Trainees are provided with a comprehensive manual (AHF, 1996) that includes AHF history, instructions, ideas, samples, and educational materials such as test values, a glossary of medical terms, and health statistics for the State.

As valuable as the training itself is for the individuals involved, an additional feature of the coordinator training is the chance for participants to meet other people from Alaskan communities with similar interests. A recent coordinator training in Fairbanks included participants from Huslia, Nondalton, Kotzebue, Shishmaref, Savoonga, Bethel, Newtok, and other rural and urban sites, allowing residents of the State to share their ideas about health care promotion in their communities, to brainstorm about future possibilities for prevention-oriented work, and to plan for collaborative efforts.

There is a site fee of $500 for each fair, which covers administrative costs, materials, forms, equipment, shipping fees, etc. However, AHF tries to keep the cost to the community of the fair at a minimum, so this fee is negotiable and can be reduced or even waived depending on the resources of the community. The fairs are free to people who attend them, with the exception of blood testing, which costs a minimal amount. In 1996, there were 106 health fairs held throughout the State of Alaska, approximately 60 percent of which were in rural communities (Judith Muller, personal communication, July 1997).

AHF is designed in such a way that it gives communities interested in improving their future health status a way to explore and learn with minimal outside involvement. An AHF event is organized, staffed (primarily), and run by local volunteers. Since the community itself is in charge of the health fair and what it contains, it is possible for villages to add and change things that they feel are important in their setting. The sense of ownership and control on the part of the host village or town brings more people into the fair and can provide a real sense of pride and accomplishment upon completion.

Community-Based Suicide Prevention Program

A 1988 study of suicide in Alaska conducted for the Alaska Senate Special Committee on Suicide Prevention documented Alaska's serious problem with high rates of suicide and suicide attempts. Following this study, the State's legislature appropriated funds to begin a new primary prevention program, the Community-Based Suicide Prevention (CBSP) program administered by the Department of Health and Social Services (ANC, 1994; Forbes, 1994). The CBSP program, administered by the State's Rural and Native Services Coordinator Susan Soule, budgets approximately $850,000 per year for projects designed to build community capacity, target high risk populations, or both. Founded on the principles and practices of community development, the program has empowered a number of villages to implement projects that they have designed locally, based on their own assessment of community strengths, weaknesses, problems, and visions. The projects vary depending on what

best fits a particular context and have included such activities as the direct provision of counseling, teen centers, 24-hour drop-in centers, public community events such as potlucks and performances, afterschool programs, education events and workshops covering a range of topics related to wellness, and elder and youth awareness projects. Projects aim to build self-esteem, cultural pride, respect, family bondedness and wellness, coping skills, and community and individual spirituality. Many of the projects specifically target alcohol, inhalants, and other controlled substances that affect both children and adults.

Starting with 48 projects in 1989, the program has grown to include 60 projects serving 63 communities in 1993. Of the original group of 48 grants, 25 (52 percent) programs are still functioning. There are emerging indications that these projects are in fact resulting in positive change in the communities. A recent evaluation of the program has found that village projects serve as catalysts to advance other important community-based responses to self-destructive behavior.... "As a group, the communities that have implemented their own suicide prevention projects with State funding from this program have shown a 51 percent drop in suicide" (ANC, 1994, p. 46).

Initially, it was planned that project funding would be gradually phased out and the communities would take over support of their projects. However, by fiscal year 1991, the CBSP had shifted to a policy in which the state recognized that each project would need some base level of funding in order to continue (Forbes, 1994). Not only are communities encouraged to develop their own projects and then empowered to implement them with State funding (an approach which is dramatically different from other State-funded behavioral health programs), but the program supports and provides community development specialists who help communities formulate their plans and express them in proposals. This process minimizes the instances of well-intentioned communities failing to receive funds due to technical problems with their proposal (ANC, 1994). In addition, regional groups are brought together at project coordinator conferences in order to share their activities. The monthly *Community-Based Suicide Prevention Program Newsletter* provides

updates on current projects as well as information about upcoming events; funding resources and changes; and descriptions of innovative local, national, and international projects. Given the geographic isolation of villages, the stress on communication and information sharing is critical to success of efforts to build a statewide prevention effort.

HIV/AIDS Education and Prevention

The challenge of providing HIV/AIDS resources to rural Alaska currently is being met at a State administrative level by the Alaska Native Health Board AIDS Project. The Project began in 1988 and was initially funded directly by the CDC. It is now funded partially by State grants and a 5-year subcontract with the National Native American AIDS Prevention Center (NNAAPC). The first 2 years of the project were directed toward understanding rural Alaskans' levels of knowledge about HIV and was followed by an awareness-building campaign using a mass media approach involving posters, videos, and public service announcements. A 1990 Knowledge, Attitudes, and Beliefs Survey indicated that Native communities are aware of AIDS, know what HIV is and how it is transmitted, and know that condoms are an effective barrier in preventing HIV infection (Joseph Cantil, personal communication, July 1997).

In the recent past, the ANHB education and prevention team traveled extensively throughout Alaska to present at health fairs, schools, and community meetings. They often stayed in the villages talking with people, were there as a resource, and answered people's questions. At the request of NNAAPC, the project is no longer responding to requests for local education. The project administrators, along with NNAAPC, realized that such an approach, while providing information to the villages, was not creating an infrastructure within rural Alaska for HIV/AIDS prevention. The AIDS Project is now targeting their efforts at a more administrative level, working on capacity building with the regional health corporations, helping regions realize the need for HIV/AIDS resources at a local level, and working with them to develop their capacity to provide these services to rural Alaskans. The AIDS Project is currently focus-

ing its efforts at training regional providers, showing them how to develop networks and identify resources (Joseph Cantil, personal communication, July 1997).

The AIDS Project staff travel to regional centers to provide intensive training that lasts up to 3 days and draws people from various communities together. This training provides participants with basic knowledge about HIV/AIDS and a framework for addressing it within their communities. The training highlights topics unique to Native communities and rural Alaska and tries to provide a culturally sensitive way of approaching HIV/AIDS (ANHB AIDS Project, 1996). This training is a main part of the ANHB approach to HIV/AIDS education in rural Alaska and is a valuable resource for networking HIV/AIDS educators in rural regions. Additionally, the AIDS prevention team continues to attend meetings such as the Rural Providers Conferences, the annual Bilingual Conference, AFN Youth/Elder Meetings, and the World Eskimo Indian Olympics, where they set up tables and have information, brochures, posters, condoms, and clothing items available.

Regional Prevention and Research Efforts

Maniilaq Health Corporation HIV/AIDS Education Program

At a regional level, individual Native corporations are developing grass-roots approaches more specific to their cultural environments. As an example, Maniilaq Health Corporation (MHC) in Kotzebue, which has a very active HIV/AIDS education program, has found that successful prevention happens when individual villages express a desire to learn and invite their health educator to make a presentation (Barbara Cohea, personal communication, July 1997).

The health educators strive to make presentations as appropriate to the region as possible; thus, the methods are constantly evolving. One approach is to make the presentations feel more like a talking circle by setting chairs in a circle or semicircle. Each session begins with a prayer of thanks to the Creator for bringing the participants together in order to express the under-

standing that nothing happens at random. The programs are highly interactive with the presenter engaging and talking with participants as much as possible. MHC educators use videos that feature Native American actors and videos of testimonials. Listening to personal stories, particularly those of Native American PWAs, is one of the most effective mechanisms for starting conversation and furthering interactive learning. Finally, local MHC educators understand that they are inviting their participants into their home and that the educators are the hosts. As a result, they have learned to provide plenty of food and beverages for participants (Barbara Cohea, personal communication, July 1997).

This type of locally run program has the advantage of being able to respond to the unique situations presented by their region. There are often great difficulties in bridging the gap between urban and rural areas when doing health education (Barbara Cohea, personal communication, July 1997). In rural Alaska, people are sometimes suspicious of people coming in from Anchorage, Juneau, or Fairbanks. Additionally, it is impossible for a person who lives in urban Alaska, or even in rural Alaska, to know how to approach all of the different villages. The villages of Alaska present such diversity that the common "one size fits all" approach does not work. As a result, grassroots programs work best.

MHC health educators also attend and present at town meetings and schools, staff booths at health fairs, make public service announcements, read articles on the radio, provide posters to villages, advertise in the *Arctic Sounder* newspaper, and loan educational videos to village television stations. MHC recently supported a student from the Alaska Technical Center in Kotzebue who produced an HIV/AIDS brochure from a Native perspective. Additionally, MHC provides continuing education training for Alcoholism Program educators (Barbara Cohea, personal communication, July 1997).

Obviously, there are different approaches to HIV/AIDS education throughout rural Alaska. The one thing that is clear to all educators and providers involved is that increasing awareness that HIV/AIDS is a threat to rural Alaska needs to be a top pri-

ority. With other more visible issues at hand, such as alcoholism and drug abuse, it is easy for villages to overlook the very real threat of HIV/AIDS in their communities. As a result, programs as different as ANHB and Maniilaq each serve necessary functions and can act as models for future endeavors.

Alaska Siberia Medical Research Program: Diabetes and Coronary Heart Disease Prevention

The Alaska Siberia Medical Research Program (ASMRP) is focused on identifying and preventing diabetes and coronary heart disease (CHD) in Alaska Native people. The project, headed up by Sven Ebbesson at the University of Alaska Fairbanks, was introduced in response to concern among Alaska Native people and researchers about an apparent increase in prevalence of type 2 diabetes mellitus (DM) and CHD within Alaska's various Native groups. Prior to the mid-1980s it was believed that type 2 DM was rare in Alaska Native populations and earlier research showed an estimated prevalence of 1.7 percent among Central Yup'iks (Mouratoff, Carroll & Scott, 1967). The first task performed by ASMRP was a thorough screening of interested Siberian Yup'ik people over the age of 25 on St. Lawrence Island, and in one Central Yup'ik village and one Inupiat village, both of which were on the mainland coast. The screening consisted of a nutrition survey, a personal interview, a physical exam including an electrocardiograph, urine and blood sample collection, and glucose-tolerance tests.

The results of this screening were worrisome to those involved in the project, since they illustrated a trend of increasing type 2 DM prevalence following the modernization of lifestyle, a trend similarly reported in studies of indigenous groups throughout the world (Ali, Tan, Sakinah et al., 1993; Bennett & Knowler, 1979; Knowler, Pettit, Bennet et al., 1983). According to a 1992 screening, the rate of type 2 DM among Siberian Yup'ik villagers was 9.0 percent (Schraer, Ebbeson, Adler et al., 1996). By 1994, this same population had an age-adjusted prevalence rate of type 2 DM of 6.3 percent for men and 12.5 percent for women (Ebbesson, Schraer et al., 1996). Further, in comparison with Siberian Yup'iks of Russia's

Chukotka Peninsula, prevalence rates in Alaska were 10 times higher. The Siberian Yup'ik people of Alaska and Russia provide excellent comparison groups because of their close genetic relationship to one another through common intermarriage prior to the closing of the Iron Curtain. One difference is that the Chukotkan people have maintained a largely traditional lifestyle (Young, Schraer, & Shubnikoff et al., 1992).

ASMRP's intervention program is based on the hypothesis that a major factor contributing to the current rise in the rate of type 2 DM among Alaskan Siberian Yup'iks is their adoption of a Westernized lifestyle consisting of reduced physical activity, increased overall food consumption, and increased saturated fats consumption. The overall aim of the intervention program is to advocate movement back to a more traditional way of life. Dietary considerations vary between villages and cultures, but desired changes include eating more traditional foods such as seal, whale, walrus, reindeer, sea greens, and marine mammal oils as well as substituting healthier Western alternatives for cooking, such as canola or olive oil instead of lard and vegetable shortening. It also involves reducing consumption of unhealthy foods such as soda, fried foods, bacon, refined sugar, coffee, potato chips, cookies, and fatty meats. In order to facilitate the desired dietary changes, project staff meet regularly with village store owners to advise them about which foods to stock. In addition, the project works with the company that supplies the village stores to increase the availability of foods that ASMRP feels are needed in the villages. Since the beginning of the intervention, project staff have seen a dramatic change in the availability of healthy alternatives, and the owners report that many of the new items sell very well. The physical activity portion of the intervention aims to reduce villagers' sedentary lifestyle changes by developing knowledge of the importance of minimal exercise and by providing organized means of increasing activity.

The project identified members of four Yup'ik and Inupiat villages around Alaska's Norton Sound region who either currently have or are at increased risk of developing type 2 DM, CHD, or both. With this population, ASMRP goals are to

develop, implement, and compare two culturally sensitive interventions within the villages and to evaluate their success with a final screening of all active participants. Two villages receive community-based intervention strategies, while the other two villages receive individual-oriented strategies. In developing the content of these strategies, ASMRP team members met with village health councils, government officials, and residents to brainstorm about possible effective mechanisms of intervention and to find out what people in the villages would like to see done.

The community-based intervention consists of mailings and letters sent to all participants that provide information that is deemed helpful and essential by the research team. It also includes town meetings, presentations, and exposure to materials through the local health clinics. Finally, it utilizes local media services such as village television stations and radio broadcasts. The regular mailings include letters that keep participants apprised of what is happening with the program and what has been found regarding the health status of their communities. The letters also encourage participants to return to healthier, more traditional ways of life. Included are lists of foods to eat and foods to avoid, as well as suggestions of ways to increase their level of activity.

The individual-oriented approach consists of visits to each home by members of the ASMRP research team to interview and talk with each participant about the health concerns for their village, the dietary changes that are advised, and the need for increased physical activity. The interview is structured and includes questions about the person's amount of walking; whether they are trying to lose weight; and a nutrition inventory that includes a list of foods and asks if the person ate the item in the last week, how many times they ate it, and for how many years they have eaten it. Throughout the interview, this inventory is used as a tool to introduce ideas about healthier eating habits.

The second phase of the prevention program involves hiring and training of a full-time intervention worker in each of the villages. This local individual will run the programs for their village and, along with ASMRP staff, will deliver the new inter-

vention methods. It is believed that the only way to achieve a successful and lasting change in risk behaviors is if the push for change comes from someone who is a member of the community. On the advice of village residents, a strong emphasis on dance as a form of physical activity will be expressed. An aerobics video that includes two young Native women as the dancers and one Caucasian instructor has been made for use in the villages. Also, exercise bikes will be made available in each of the villages. The bikes were chosen for their ease of use and sturdiness and because they allow the user to work at a comfortable pace. Classes in dietary choices, dance, and cooking will be added, as will organized Native dances and interactive health discussions.

The Road Back: A Village-Based Prevention Strategy[1]

The Council of Athabascan Tribal Governments (CATG) was formed in 1985 as a response by the Chiefs of the Yukon Flats region to unify their voices against the threat of opening the Arctic National Wildlife Refuge to oil exploration, thereby invading the Porcupine Caribou herd's calving grounds and threatening the existence of the herd and the subsistence lifestyle of the people. Since this time, the CATG has begun a process of increasing the quality of life in all 10 villages of the upper Yukon Flats by taking on projects that employ and empower local Athabascan people.

CATG villages are located in the Yukon River Valley between the Brooks Range and the White Mountains from the Canadian border to below the Dalton highway where the village of Rampart marks the farthest village down the Yukon River in the consortium. The villages that comprise the CATG are Arctic Village, Beaver, Birch Creek, Canyon Village, Chalkyitsik, Circle, Fort Yukon, Rampart, Stevens Village, and Venetie. The dominant culture of the area is Athabascan, including the Gwich'in and Koyukon dialects. The Council of Athabascan Tribal Governments has long been aware of the social issues that exist in the communities and takes into consideration the history of Alaska Natives as one of the greatest causes of substance abuse. The process of healing therefore includes taking into considera-

tion the economic, educational, political, and social histories. Prevention programs need to be flexible in order to address the issues most relevant to the villages on an individual basis.

A Center for Substance Abuse Prevention (CSAP) Community Prevention Coalition Demonstration grant was awarded to the CATG, and The Road Back: A Village-Based Prevention Strategy was implemented. This 5-year demonstration project has three goals. The first is to form a community alcohol and drug abuse prevention coalition at regional and local levels in the Gwich'in Athabascan villages of the upper Yukon drainage. The coalition consists of existing and new partnerships and involves the expansion of long-range, comprehensive, multidisciplinary, community-wide, and regional substance abuse prevention programming. The second is to further develop and enhance culturally competent preventive education and training programs in the proposed partnership area. The third goal is to expand and enhance culturally competent substance abuse prevention programming across an expanded geographical area through partnership development and local prevention linkages.

Each of the village's Tribal Councils acts as the direct supervisor of the Prevention Workers and provides the direction of the prevention programs. Some of the villages use the coalition-building process as the priority of the prevention program, while others concentrate more on prevention in the school or on using and enhancing cultural practices and knowledge. In all cases, the village prevention program is seen as one whose ownership is based at the village level, as a part of community development. For example, in Arctic Village, Prevention Worker Kenneth Frank coordinated three age groups of students on three camping trips to climb the surrounding mountains. The mountains around the village are 2,500, 3,000, and 6,000 feet high. Some of the students had lived in the village all of their lives but none had climbed the mountains before these outings. Once on the mountain peaks, the youth ate and discussed their sense of accomplishment and pride in overcoming their fear and reaching their goal. Prevention Workers in Rampart (Margaret Moses), Stevens Village, and Venetie have sponsored similar

prevention activities involving camping, moose hunting, and trips involving subsistence activities.

In Beaver, Prevention Worker Francine Henry collaborated with the Beaver Tribal Council to facilitate the 4th of July festivities. Ms. Henry has an active youth group that is made up of youth who meet to have a sewing group; she has also had slumber parties to discuss substance abuse issues. The Prevention Worker in Arctic Village (Mr. Frank) started two sweat lodge groups, a women's and a men's group that include both youth and older adults. In the sweat lodge, traditional customs are practiced and sobriety dates are celebrated.

In Chalkyitsik, Prevention Worker Minnie Salmon collaborated with the village Tribal Council and Indian Child Welfare Act Worker to facilitate a camp up the Black River with 15 students. The majority of the time was spent on cultural activities at the camp. A caribou hide boat and dog pack were made along with lessons on how to knit a fish net. The fish net was not completed at the end of the week-long camp but plans were made to finish it with the youth over the winter. In addition to the cultural activities, lessons on drug and alcohol addiction were provided. The camp ended with two of the oldest students, both young women, paddling the skin boat down river to the village. When they arrived the village residents and everyone from the camp were waiting on the bank to greet them: one of the many historic moments created by the CATG/CSAP prevention project. Cultural camps were also held by the Prevention Workers in Canyon Village (Delma Fields) and Venetie.

In Circle, Prevention Worker Margaret Henry John has collaborated with the village Tribal Council to open a community center. The youth have a pool table and organized games with prizes. There is an outdoor volleyball net for all that want to play and participate. The Fort Yukon Prevention Worker, Kimberly Carlo, initiated a traditional Native dance group for teenage youth, which performed at the annual Festival of Native Arts in Fairbanks, and the Quyanna night during the AFN's annual convention in Anchorage. The Quyanna night event was broadcast over the rural communication system and viewed in more than 200 villages. Richard James, the Prevention

Worker in Birch Creek, combined resources with the school district to also sponsor a youth Native dance group at the Festival of Native Arts.

Stevens Village youth, with the leadership of Prevention Worker Cheryl Mayo-Kriska and in collaboration with the school and village Tribal Council, toured one of the Trans-Alaska Pipeline's pump stations and a local fish camp and museum. Prevention Worker Judy Erick (Venetie) said, "as a result of camping and spending quality time with each child, the kids I work with are closer to me, have trust in me, and are not afraid to talk to me about anything."

All Prevention Workers are employed directly by the Council of Athabascan Tribal Governments, which administers the grant. Also employed by the grant is a Counselor/Supervisor, Floris Johnson, and a Project Director/Evaluation Coordinator, Charleen Fisher. The Counselor/Supervisor provides technical support and acts as a resource for the Prevention Workers and communities. In addition to basic project administration, the Project Director works with the Counselor/Supervisor and the Prevention Workers on report and evaluation activities that keep the project in compliance with grant requirements. All the employees of The Road Back: A Village-Based Prevention Strategy are Alaska Native People from the villages in which they work.

The Road Back: A Village-Based Prevention Strategy has a program design that fits the new paradigm, an empowerment approach to prevention programs. It therefore was essential that evaluation of the program also fit this paradigm. The following were recommended steps for evaluating the prevention program, as developed by the CATG staff and consultant Dr. Alicia Martinez. The process for evaluating the success of The Road Back: A Village-Based Prevention Strategy begins with each community's Prevention Worker. This is part of the program's effort for self-determination. The evaluation involves the following steps:

- Step 1: The Prevention Worker and community collaborate to carefully specify the target group.

- Step 2: The Prevention Worker presents two alternative proposals related to drug and alcohol abuse to the community for discussion and selection.
- Step 3: A representative group of participants is selected to be interviewed.
- Step 4: The Prevention Worker conducts and documents the prevention activity.
- Step 5: The Prevention Worker conducts interviews with selected participants on effects of the activity soon after the activity is held.
- Step 6: A followup interview with the target group participants is scheduled and conducted at a later date, if possible.
- Step 7: Interviews are transcribed and reviewed for essential common patterns.
- Step 8: Reports are written, making sure that the information presented is valuable to the community.

The results of this process are then made into a booklet and distributed to the villages as a way to celebrate healthy activities. The prevention effort by the CATG is an innovative approach to prevention. While most substance abuse prevention efforts consist of only two activities, and slightly less than 25 percent of the programs supported by CSAP consist of three or more activities, the CATG prevention program has the potential for 10 activities to be developed and conducted at any one time, therefore making it a unique program. The CATG prevention program illustrates how Alaska Native people are working to determine their own destiny and providing important information for future substance abuse prevention efforts.

Spirit Camps

A tradition exists within Alaska Native communities of summer fish camps to harvest and prepare fish for the family (Kawagley, 1995). Fish camps involve an extended family process in which generations come together to work and share the responsibility of catching, cutting, drying, smoking, and packaging for storage hundreds of fish (primarily salmon), ensuring that the family

has adequate food for the winter. In addition to harvesting fish, camp members may harvest berries and use the camps as hunting camps during various times in the year. During the early part of the 1980s, the Northwest Arctic Natives Association (NANA) began a process of inviting elders to meet in order to articulate the central values associated with being an Inupiat. The NANA spirit movement was born from this process along with a commitment to transmit these values to young people in order to ensure the survival of Inupiat culture and to prevent anomie and alienation as well as substance abuse and suicide. Cultural camps, modeled on the summer fish camps, were designed to reintegrate young people into community subsistence activities and to expose young people to the teaching of values by elders. These camps were almost entirely focused on youth and adolescents rather than on young and middle-aged adults. The feeling of NANA leaders was that they needed to focus on the health of the youth in order to ensure strength for the future.

During the same time, Donald Peter, Director of the University of Alaska Fairbanks Alaska Native Human Resource Development Program, initiated a similar process with tribal elders (primarily but not entirely from Athabascan tribal groups) through the Respiritualization Task Force (Hampton, Hampton, Kinunwa, & Kinunwa, 1995). They generated the idea of sponsoring spirit camps as a place where tribal elders could transmit their knowledge and values both through talking to participants and through the rhythm and the activities of the camp. The camp would be a healing place (Katz & Craig, 1987). Camps vary in type: some are youth-oriented, some are family-focused, and some are engaged in alcohol detoxification and recovery. The idea of spirit camps has been embraced by tribal groups throughout Alaska and is frequently being used for alcohol treatment. Two of the most well known camps are the Ga'alleya Spirit Camp of elder Howard Luke and the Old Minto Cultural Heritage Camp led by Robert Charlie and elders from Minto. Also located at the Old Minto village site is a recovery camp that is operated by the interior tribal corporation, Tanana Chiefs Conference.

The typical framework for spirit camps such as Ga'alleya is for participants to come for a 1-week stay. They camp in tents or live in log houses and work with tribal elders on a variety of projects such as wood gathering, building structures, processing fish and berries, and other traditional fish camp activities. During the day and in the evening, the group gathers for talking circles. These circles have been modeled on American Indian ceremonial structures such as healing ceremonies and purification rites, in which individuals sit in a circle and each person speaks without interruption. Talking circles typically demand that individuals remain in the group until the circle is finished. A sacred object such as an eagle feather is passed from person to person, which they hold while they speak. No topic is forced on the speaker. They speak and participants respectfully listen. During these periods, participants may tell personal stories of their struggles and growth. Elders may share their personal stories or particular cultural stories that belong to them or to their group. Howard Luke often speaks to the participants early on about *Alleya* (luck) and the weasel that would come to visit the people's homes. The weasel would knock on the door, look into the home, and examine it to see if the residents live in harmony and respect. Was it a clean home? Were the animals who were hunted prepared in a respectful way? Did the people speak to each other with respect and love each other, especially the children? If the weasel saw a respectful house, *Alleya* would enter and stay with them. Such stories dramatically teach the participants about deep cultural meanings concerning how one should live. They both inspire and teach. In the Old Minto camp, such events frequently happen. Elders speak strongly about cultural values and about rules for conducting oneself within the family and community.

In the NANA region, camps were used to bring people who sought help with health and other problems into interaction with traditional Alaska Native healers. Camps in that region were often held at traditional hot springs and allowed individuals to be doctored by the healers. Although no longitudinal study is available concerning the effectiveness of spirit camps for alcohol recovery, case studies have discussed the conceptual

model and how strongly it resonates with Alaska Native values and aspirations (Hampton et al., 1995; Hughes, 1997).

> *Spirit camps provide a foundation for community development. An individual community member could have a substantial effect on community healing by working with others to identify traditional sources of strength and implement projects based on these traditions.... These models are valuable not only because they connect us with the traditions of the people and our true selves but also because nature is a sacred and healing place that helps us to be wise and creative as we work towards our future. (Hampton et al., 1995, p. 263)*

Policies to Control Access to Alcohol

Prior to the purchase of Alaska, alcohol had been a commodity for trade between the Russians and the Native people of Alaska (Anderson, 1988). After the purchase of Alaska by the United States, Alaska Natives lived with prohibition until 1953. After 1953, alcohol availability did not change appreciably until 1962. Historically the relationship of the United States to alcohol use by Alaska Natives has been the exercise of external power:

> *The assumption of Native inability to exercise self-control over the use of alcohol originated with contact. Teachers and missionaries saw suppression of drinking as the prerequisite for civilizing the Natives; they actively advocated law enforcement efforts to protect Natives from whites and to protect them from themselves.... The majority of the alcohol control legislation since that time has originated externally to local communities and has had Natives as its specified or unspecified target.... Thus, before the turn of the century, non-local controls, widespread organized violation, race-selective enforcement, and local Native enforcement personnel were all present as, to some extent, they remain today." (Lonner & Duff, 1983, p. II, 2–3)*

Historically, alcohol use was strictly controlled by elders, chiefs, and councils and by the remoteness of villages. This resulted in a lack of access and the absence of alcohol-related social prob-

lems. In many villages, a history of making home brew existed and its availability was patterned for use during celebrations. Informal and formal controls at the community level prevented widespread behavioral violations of an interpersonal nature. It appears that after 1962 alcohol abuse increased as the cash economy grew and families were split by boarding school, work, and other forms of out-migration and increased contact. Still, local formal and informal controls existed and were enforced. Studies suggest (Lee, 1994; Lonner & Duff, 1983) that the more traditional the village, the stronger the controls and the fewer the alcohol-related problems. In the mid-seventies, there was a serious effort on the part of state and local leaders in the Native and non-Native community to develop new legal forms to control alcohol use through a local form of prohibition.

In 1981, the Alaska Local Option Law (ALOW) was passed by the legislature, with additional options amended in 1988 (Alaska Department of Community and Regional Affairs, 1995). It is applicable to any community in the State, but has only been used by communities that are predominantly Alaska Native. The law allows a community to vote on whether to restrict the sale, possession, or importation of alcoholic beverages into a community. Violations are either misdemeanors or felonies and a variety of sanctions exist, including jail and fines.

Local option has become widespread in regional centers and villages throughout rural Alaska. A recent study (Berman & Hull, 1997) reported that 37 percent of rural communities have approved restrictions under ALOW. Of the 92 communities that have banned alcohol, 11 percent banned the sale only, 59 percent banned both the sale and importation, and 30 percent banned the sale, importation, and possession of alcohol. None of the largest, road-connected communities have approved local option controls. Berman and Hull (1997) further reported that "from 1981 through 1994, 99 communities held 148 local option elections that either added or removed restrictions on alcohol... relatively few communities have tried and failed to exercise some control under the local option law" (p. 2).

The authors further estimated that approximately 52 percent of the Alaska Native population, compared with 11 percent of

Alaska's total population, live in places that restrict the availability of alcohol. The effectiveness of such control in the reduction of either alcoholism or the social problems associated with alcohol abuse has not been adequately documented.

> *It has become clear over the years that although the local option law has had a positive effect in some villages, in others the impact has been minimal, due either to a vacillating vote or to the continuing problem of bootlegging. (ANC, 1994, p. 44)*

Lonner and Duff (1983) indicated great variations in the effect of the law based on how strongly the community accepted and supported it, how well they supported the local village public safety officer, and how strong and intact the village was at an informal control level. They report the experience of many Native people, which points to the importance of a village suddenly becoming dry. People spoke of how the parties stopped, how they were no longer afraid, and how they had more time for their children and subsistence activities. Certainly, people began to find ways to drink by leaving the village or sneaking in alcohol, but Lonner and Duff indicated that the stronger the local controls were, the less abuse and the fewer social problems occurred. Further, recent research reported by the State's Section of Epidemiology (Propst & Landen, 1996) found less restrictive alcohol laws were associated with higher alcohol-related injury deaths and concluded that measures limiting access to alcoholic beverages in rural villages may decrease alcohol-related injury deaths.

The local option also has a powerful symbolic value. It communicates to the people that they have control, that they have and can exercise community standards for behavior, and that they can demand their enforcement. The result has been a growth in sense of community responsibility and "control over community" (Lonner & Duff, 1983, p. XII-26). The ANC (1994) emphasized the importance of empowerment through self-reliance and self-governance in order for communities to reestablish a functional social order:

Alaska Natives are residents of the nation and the state, but they also occupy their own cultural and political communities. Native villages and their tribal governments—as distinct partners with the state and federal governments—must be entrusted with the social and political decisions critical to Alaska Natives future well-being and survival. The validity of Alaska Native cultural perspectives...must be recognized and afforded due respect.... If significant improvements are to be made with respect to overall Alaska Native well-being, the native community must take ownership of the problems and assume responsibility for the solutions....

Any future attempts to regulate alcohol importation and use in Alaska Native villages—as well as the enforcement, prosecutorial, and sentencing powers and resources without which such regulation is meaningless—must be premised on the fundamental belief that Alaska Natives can and should have ultimate and unquestioned control...a continuation of historic and present approaches to the issue should be deemed unacceptable by those who genuinely care about the future well-being of Alaska Natives. (pp. 60, 64, 77)

Conclusion

We have been able to provide an overview of only a smattering of the numerous projects and interventions that have been designed and carried out by Alaska Native people and their communities. For those who wish further information, the ANHB (1994) provides an excellent resource manual that includes many other examples of both individual and community prevention activities as well as how-to's and resource listings. We also refer you to prevention projects documented by McDiarmid (1983) and Marum (1988) and the discussion by Hild (1987).

In light of the high rates of alcoholism and other negative social and health indicators, the reader may wonder whether the interventions we have described are effective. First, it is clear

from epidemiology reports that social indicators have not gone from bad to worse in all cases. In problem areas where target intervention programs have been at work long enough to see summative changes, we do see indications of progress in harm reduction, e.g., in accidents and drowning. In regard to suicide prevention, evaluations of the small demonstration grants indicate progress in those villages that have focused their efforts on prevention. Further, the early data from diabetes prevention programs indicate that rapid increase of diabetes is not occurring in villages, as would be expected without the intervention. These results suggest that targeted prevention efforts that build upon local knowledge and strengths are making a difference.

Yet there are other areas of significance in which it appears that little is changing (e.g., alcoholism, domestic violence, and HIV/AIDS). Although there has been a long history of intervention in alcohol abuse, it is only in recent times that interventions have integrated indigenous knowledge in the planning and operation of preventive and treatment-oriented interventions. Most prevention models and strategies have historically been imported from outside of Alaska and based upon Western paradigms. Planners need not conceptualize the process of building new indigenous interventions to mean that Western methods have no applicability. Our sense is that this polarizes the planning and intervention process and ignores the key question of what will work best for a particular problem and context. An integrated approach or parallel structured interventions in which Native and Western approaches work together may work best. Currently, new models are being considered that come out of Alaska Native paradigms. To develop such interventions, one must clearly articulate the paradigm. This is neither simple nor easy. It is time-consuming, both in determining the local knowledge applicable to a particular problem and in determining how best to apply that knowledge. In the real world of practice, this process often occurs in a context of limited resources, a demand for immediate action, and application prior to clear articulation and planning. Such a process results in significant time spent in trial-and-error learning, and therefore one should not expect immediate summative results.

Consequently, formative evaluation makes the most sense at this time, and only at later stages can one make a case for seeing significant changes at a summative level. We have seen that such formative evaluations point to significant ways in which communities are improving their situation (for example, see McDiarmid's 1983 analysis of the Chevak Village Youth Organization). The need for formative evaluation is particularly important in many problem areas such as HIV/AIDS that are only beginning to be addressed in Alaskan villages. Interventions in these areas need to be monitored carefully in order to understand and take into account the ways in which complex health and social problems are interrelated.

In reviewing the diverse prevention and health education efforts, we have drawn a number of inferences that are critical features of work in rural Alaska. They are summarized here as recommendations and considerations for anyone doing prevention work in the area of health, behavioral health, and alcohol and substance abuse prevention in Alaska, and they are based on what we consider the essential features of those promising practices which have been recently developed.

Know the Context, Particularly Its Rural Nature

Alaska and especially rural Alaska is a complex and diverse setting. Rural means different things in different parts of the United States. If Freud thought biology was destiny, in rural Alaska perhaps geography and culture are destiny. Distance, weather, and the pace of life demand significant patience, a willingness to slow down and wait, and flexibility from prevention workers.

The diversity of Alaskan weather and topography is matched by the diversity of its people's culture and language. Those working in the area of rural prevention must learn the specific cultural ways of the groups with whom they work. Pan-Native, "one size fits all" conceptualizations should be avoided. They hide the real nature of Alaska Native cultural diversity. Additionally, solutions coming from a traditional framework must originate from local knowledge. The process of prevention

should develop local knowledge and wisdom rather than depend on generalized ideas and stereotypes.

Local, Face-to-Face Communities Present Special Dilemmas and Challenges to One's Paradigms and Approaches

Alaska Native villages are face-to-face, kinship, relational-based communities. Everyone relates through kinship. Everyone has long memories and significant experience with each other. This serves both to facilitate and to hamper change. For the person working to prevent and treat alcohol and drug abuse, it means that they must know the community and take the time to build relationships and trust. People and communities are the authors of their lives, and the community-based helper must orient themselves to work *with* the community. The prevention worker should assist community members in finding and developing their own ability to choose and compose solutions to their problems, not do the choosing and composing for them.

Rodenhauser (1994), in reviewing cultural barriers to health care delivery in Alaska, also emphasized the need for service providers to refrain from imposing their values and cultures on the communities, to respect and practice local communication styles, to become part of the village culture and work together with Native healers, to incorporate a local understanding of the problem and its solution, and to assist with restorative efforts at the community level.

Prevention programs should hire and train local people familiar with the setting. Consistent with the emphasis of the ANC (1994), developing local capabilities is essential:

> *Solutions to the health problems of Alaska Natives lie, then, not simply in health care but more generally in empowerment and involvement of Alaska Native communities in the design, implementation and control of their own programs...that will enable them to regain control of their collective futures. Only by means of re-establishing community control and empowering local decision making can the responsibility for ensuring healthy lifestyles be regained by the community; only through*

this process can the individual and the family be reached in any meaningful way that will turn the tide of deteriorating health status among Alaska Native people. (p. 42)

However, when this is done agencies must realize that local people carry with them the history of their family name and personal acts, so programs must consider this in both training and supervision. They must help local workers learn how to work in their own communities without becoming trapped by who they are thought to be because of their own family or personal history. They will need assistance in learning how to negotiate complex new relationships as a helper, which includes how to maintain confidentiality and build trust, how to maintain their role as a natural helper, and how to work within kinship relationships.

Trauma Is Communal, So Interventions Must be Communal

Within Native communities the trauma experienced is fundamentally communal and often historical. Alaska Native communities have suffered a great deal of trauma. Some of it is from epidemics; other traumas are from deculturational stressors such as formal schooling, boarding schools, religions, and economic oppression.

The Commission has determined that many of the causes for today's upheaval in Alaska Native communities and within families can be found in their often tragic experiences since contact with Europeans, and in the cultural, social, political and economic climate created for them by both federal and state governments. At the core of the problems are unhealed psychological and spiritual wounds and unresolved grief brought on by a centuries-long history of deaths by epidemics, and cultural and political deprivation at others' hands. Some of the more tragic consequences include the erosion of Native languages "in which are couched the full cultural and spiritual understanding" and the shattering of cultural value systems. (ANC, 1994, p. 57)

Harold Napoleon (1991), a Yup'ik man from Hooper Bay, has argued that this weakening of Native cultural traditions and values and the trauma associated with acculturation practices of Western institutions are the primary causes of alcohol problems among Alaska Natives. "Through my own studies...and by listening to elders, I have come to the conclusion that the primary cause of alcoholism is not physical but spiritual" (p. 2).

Each village has its own history of trauma. However, any trauma, whether it has historical dimensions or is an individual trauma, affects the community as a whole. When an elder dies, a suicide happens, an accident kills, the whole community is affected, and other communities in the region also feel the impact. Grief and loss are contagious. To heal, one must look beyond the individual to the community and family as a whole. "The emphasis in all substance abuse prevention and treatment efforts must be the community, and within the community, the family" (ANC, 1994, p. 44). Interventions described in this chapter point to ways in which rural villages and Native communities have developed community and family-based interventions.

Interventions Should Arise Out Of and Connect to Indigenous Knowledge Bases and Should Foster Choice

In Alaska there has been an important intellectual and cultural movement among Alaska Natives to revive and reclaim their culture and past, and to base programs, interventions, and processes of change on indigenous ways of knowing. In order to accomplish this connection, any prevention program must identify the elders and local experts who are the keepers of wisdom and see them as resources in the articulation of a knowledge base that allows the intervention to proceed in a culturally consistent way:

> *Native communities have their own standards by which they define the problems associated with the consumption of alcohol. If interventions are made, or alcohol studies undertaken, then they have to account for the Native cultural perspective. (Hild, 1987, p. 85)*

So too, Native cultures have their own conceptualizations of health and disease as well as means of prevention and healing. At times, Western and Native traditions and approaches can be synthesized. Other times, they may operate in a parallel fashion. However, when program developers or workers fail to recognize potential cultural differences in the way in which personal choice is understood, they risk intervening in ways that lead to resistance rather than commitment. Each of the innovations described above fostered personal and community choice. The sense in Alaska is that program interventions must arise out of an analysis of what makes sense to the particular Native community and what fits their history and their cultural view of health and illness. The interventions describe in this chapter follow these principles and maximize community potential.

Western Knowledge Can Be a Critical Element If It Is Contextualized Within a Culturally and Community Relevant Framework

Programs need to articulate local knowledge and create bridges to Western knowledge. A rural leader once told us that she wanted to have experts in suicide come to the village rather than just be asked to figure out the solutions and have a facilitator present. She said, "What do they think? If we knew what to do we would have done it and prevented this from happening in the first place. Sometimes we don't know and we need expertise we don't have." There exist numerous examples of how Western knowledge has been critical in eradicating disease (e.g., tuberculosis treatment and childhood vaccinations). However, even these projects need to think through the diverse cultural orientations and devise ways in which collaboration and community choice can be maximized. Behavioral health and alcohol programs must think through these same issues as we try to use Western knowledge so that it can help communities to eradicate the persistent problems confronted by rural villages.

Training and Prevention Must Foster Connectivity

From the descriptions of the innovations described, the reader can discern that training of local people is critical to prevention

work. What is so important about the Rural Human Services Certificate program is how it is done, not simply that it targets local people. The program is successful because it blends teaching of content in both Western and indigenous knowledge bases with personal development. While attending a meeting of the supervisors of rural human services workers, we were struck by the statement of one of the supervisors that community members wanted to attend the training program because they saw the impact it had on the personal development of their prevention or mental health workers. Clearly, personal development and the acquisition of knowledge and skills are integrated in this program, not separated as they are in most university education. Training programs must not separate and automatize knowledge in skill domains and independent groupings, but must provide a framework for integrating a person's development emotionally, cognitively, socially, and culturally. Education becomes a process of transformation. An indigenous model of education is operative both in process and content.

Prevention Efforts Must be Embedded Within an Empowerment Paradigm

A fundamental principle of all health promotion programs described in this chapter is that prevention work in villages should foster community ownership, self-reliance, and empowerment. Therefore, it should not be surprising when carving clubs, dance groups for youth, and traditional camps, developed by local people and communities and intended to increase the sense of competence and efficacy of the population, also aim to lower the risk and rates of behavioral health and alcohol and drug abuse problems. Organizing a dance group involves recruitment and participation of elders, negotiations about beliefs and religion, and involvement of the community in providing a place. Separate domains do not exist in the same way in a small rural village as they do in urban areas where services are provided by specialized professionals. However, villages do have institutional frameworks as well as informal turf, so that connectivity demands carefully building consensus among multiple groups.

Perhaps the most important lesson from the local option laws is that communities make a statement of what they want for the quality of life in their village. Consequently, the community does set limits to personal choice, which exist in the context of communally established values and limits. The policy dimensions of alcohol taxation and forms of prohibition relate to the importance of community choice and responsibility. Thus, evaluations of the effectiveness of these policies must not be based simply on short-term outcomes as measured by volume of alcohol bought and consumed, but on the longer-term process of the community setting and enforcing standards of behavior.

The work of prevention should become a synergistic process that creates new community resources and ways for village people to work together with each other, with agencies, and with Western professionals: a process of building and multiplying local resources and capacities. Such a model and process of prevention rejects a scarcity paradigm that depends on highly specialized and professionalized expertise and interventions, and in contrast, uses a community empowerment paradigm. Community empowerment encourages local self-care, builds local understanding and access to both Western and indigenous knowledge bases and methods, and leads to innovative village-based programs for prevention and health promotion.

Finally, in Alaska and the United States we seem at this point in history to embrace a strong belief in less government, more individualism, and less use of government funding. However, many enduring social and health problems take much more than exhortation. They take time, effort, careful planning and research, attention to supporting those doing the work, evaluation, and large amounts of time and energy from diverse individuals who possess relevant expertise. This takes adequate and consistent financial support. The current ideology that less funding for research and intervention will lead to better services is naive and significantly limits the building of prevention.

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5

Using the Community Readiness Model in Native Communities

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Abstract

The effects of alcohol and other drug abuse are recognized as a dangerous threat to communities in the United States. Policy efforts and increased law enforcement may have only a minimal impact if the prevention strategies are not consistent with the communities' level of readiness, are not culturally relevant, and are not community-specific. This article presents a model for accurately assessing a community's level of readiness to initiate prevention strategies. It introduces the concept of "community climate" and its impact on community readiness. The model can be used by community members to develop interventions appropriate to each stage of their communities' readiness, thus increasing the potential for strategies to be successful and improving the cost-effectiveness of prevention programs.

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Alcohol and other drug abuse remains a serious problem in the United States, and after a decade of decline among adolescents it is once again on the rise (Johnston, O'Malley, and Bachman, 1995). The most recent published information (Beauvais, 1996) indicates that the same patterns of abuse found among U.S. adolescents also occur among American Indian youth. These increases are occurring despite increasingly stringent national policies and the implementation of a vast array of drug and alcohol prevention programs. It is quite possible that health-oriented prevention initiatives are not as effective as they could be, since they often ignore the critical element of community readiness and its willingness to address the problems of substance abuse. Unless they are tailored to the level of a community's ability to respond to a problem, interventions will fall short of their intended goals. This chapter will describe a process for assessing and facilitating community functioning and readiness to address drug prevention.

Drug abuse prevention in American Indian and Alaska Native communities is complicated by socioeconomic conditions that present many challenges and obstacles to those communities attaining a satisfactory quality of life. Although recent years have brought some political successes, there have been few economic successes. Many Native families still experience poor nutrition, live in substandard housing, and lack the resources necessary to provide their children with choices for positive opportunities—all factors that are believed to place them at high risk for substance abuse. Many assert that when Native people live in rural communities or reservation areas, substance abuse problems may be even more pervasive because there are few effective local resources for either treatment or prevention.

When one considers the many tribal and village differences, it is not surprising that alcohol and drug use among Natives varies from one community to the next (May, 1982). May (1986) cites some tribes as having fewer drinking adults (30 percent) than the U.S. population (67 percent) while other tribal groups have more (69 percent–80 percent). Despite this variability, when American Indian populations are examined as a whole the

statistics regarding alcohol consequences are quite alarming. (See Moran in this volume for a summary of alcohol-related morbidity and mortality.) These statistics translate into communities with overwhelming challenges and too few reliable resources to address their problems. In response, too often people from outside the community come in and attempt to identify the problems and prescribe solutions. Few, however, are successful because outsiders seldom understand the dynamics and cultural nature of the community and once the person leaves, their "prescriptions" falls by the wayside.

The answer to successful prevention may lie in locally developed and implemented prevention programs. Though anecdotal evidence suggests that some prevention programs have met with success, few have been rigorously documented to ascertain the degree of their effectiveness. Because so many different sectors of a community are affected by substance use, prevention efforts are often fragmented. In truth, underemployment, poverty, prejudice, and the lack of opportunity typically mark all communities, neighborhoods, villages, and reservations that are identified with high alcohol and other drug involvement. It is therefore difficult for many communities to implement effective drug and alcohol prevention programs that are culturally specific and community relevant, when there are so many other day-to-day survival issues these communities must face. Many prevention-oriented programs have been launched in the past few decades, ranging from educational awareness to more aggressive experiential activities, but many have met with failure. The communities often had so many pressing problems to confront that they just were not ready to initiate prevention programs.

Other factors must be considered as well. For instance, smaller communities and reservation areas often have to contend with political and social factors that impact success or failure of a new program. When key people in a community are affected by alcoholism, either personally or within their families, it is often difficult to gain their collaboration and support for an alcohol-use prevention project. Without acceptance and

support for prevention endeavors from all key elements of a community, success is unlikely.

The primary purpose of this chapter is to introduce a method for assessing the level of readiness of a community to develop and implement a drug and alcohol prevention program. Steps will be discussed that will allow a community to assess readiness for program implementation and determine the climate of the community relative to the specific problem issue. Potential interventions for each stage of community readiness will be presented as well. Because under this method community members must identify their own community problems, concerns, strengths and resources, and develop their own specific strategies for intervention, the method greatly increases the potential for cultural relevance and community-specific application.

Development of the Community Readiness Concept

The initial concept of a community's "readiness" for prevention efforts evolved simultaneously from two areas of research conducted by the Tri-Ethnic Center for Prevention Research at Colorado State University: (1) consultation and training of field professionals from Mexican-American and American Indian communities by the Center's facility; and (2) a project to develop and test media programs aimed at preventing drug and alcohol abuse in small communities.

The purpose of the first project was to provide technical assistance in the development of effective prevention programming to underserved populations. The Center's "Community Team" visited sites across the United States, serving as a resource to provide information and transfer knowledge about drug and alcohol prevention. The intent was to bridge the gap between research and service provision. As the team visited numerous sites, it noted the emergence of similar themes as communities identified their concerns. The team also found that

communities experienced varying degrees of difficulty in building effective networks and coalitions and further, that underserved communities often lacked the resources to direct them in proceeding with effective prevention strategy development. As a result, the team developed a workshop and practical manual that would provide communities with the tools and instruments to assess their community strengths, resources, needs, and barriers for use in development of effective and culturally specific prevention strategies.

Initially, when the Community Team was invited into a community, it would request the community gather together the key people in it to attend the workshop. Participants then worked closely with the Community Team to identify the concerns in their area. Using these findings, the participants would devise workable and practical strategies that were both culturally appropriate and practical for that community. The community found it easier to invest in the effort because the plan was specific to their needs and consistent with their culture. Because the Community Team members had clinical backgrounds as well as research experience, it seemed only logical to apply the concept of an individual diagnostic assessment to the community as a whole. Just as an individual experiences differing stages of readiness for an intervention, so does a community.

At the same time, a second project within the Center was pilot testing a workshop to train members of ethnic communities in the various aspects of drug prevention. Small teams from ethnic communities were invited to the Center to participate in comprehensive prevention training (including needs assessment techniques, information on prevention programs, and grant writing), then sent back to their communities to initiate or improve local prevention efforts. The pilot study, however, did not yield the desired effects. Although the trainees learned a lot about prevention programming, when they returned home they had little impact in their communities. Follow-up interviews suggested that their communities did not understand the problem and were not ready to invest in prevention programming.

Although the training did not lead to significant changes in their communities, a major lesson was learned from this pilot project: when initiating or improving prevention programs, it is first necessary to prepare a community for change. Training staff in how to implement a prevention program is only appropriate when the community is ready to either initiate a program or expand an existing program.

From these experiences came the seeds of the Community Readiness Model. The two projects, relatively independent of one another, indicated the need for much more information about communities, including a method for assessing community "readiness," and then the need for development of a plan or process for moving communities to the actual planning and program implementation stages. The first steps were to create a theoretical model of community readiness and then to develop and validate methods for accurately measuring community readiness.

Theoretical Framework for Community Readiness

Researchers and practitioners alike have found that communities vary greatly in their interest and willingness to try new prevention strategies (Weisheit, 1984; Aniskiewicz and Wysong, 1990; Bukoski and Amsel, 1994). While some communities may reject public recognition of a local problem, other communities show considerable interest in an identified problem, but have little knowledge about what to do about it. Still other communities may have highly developed and sophisticated prevention programs. Before the Center's work, no standard method for describing community readiness or specific methods for assessing community readiness existed. The closest approach in the literature was community development theory, but that theory did not directly address community readiness, particularly at the earliest stages.

The Community Readiness Model was developed using two research traditions: psychological readiness for treatment and community development. Psychological readiness may be defined as an individual's sense of dissatisfaction resulting from perceived discrepancy between what is and what should be, with the subsequent motivation to seek information, to learn, and to adopt new behaviors aimed at alleviating this discrepancy. Prochaska, DiClemente, and Norcross (1992) provide the best example. They present a five-stage model for psychological readiness: (1) the *precontemplation* stage (involves minimal awareness of a problem and consequently no intent to invest in change); (2) the *contemplation* stage (includes awareness but no commitment to action), (3) the *preparation* stage (involves clear recognition of the problem and exploration of options); (4) the *action* stage (involves implementation of proposed behavioral changes); and (5) the *final maintenance* stage (includes both consolidation of behavioral changes and preventing relapses).

The field of community development provides two approaches that are partially relevant: the innovations decision-making process (Rogers, 1983) and the social action process (Warren, 1978). Garkovich (1989) has noted that both of these models recognize the complex dynamic interactions involved in a community-level, consensus-seeking, collective action. Rogers' stages for the innovation's decision-making process include knowledge (first awareness of an innovation), persuasion (changing attitudes), decision (adopting the idea), implementation (trying it out), and confirmation (where the idea is either used again or discontinued after initial trial). Warren's social action approach parallels these stages and focuses on group processes. The stages include stimulation of interest (recognition of need), initiation (development of problem definition and alternative solutions among community members who first propose new programs), legitimization (where local leaders accept the need for action), decision to act (developing specific plans which involve a wider set of community members), and action (or implementation).

The Community Readiness Scale

These concepts, and the Center's experiences, provided an initial framework from which to create a model as well as to develop a method for actually assessing community readiness. Using a series of interactive steps based on expert raters and the Delphi method, followed by several revisions, a nine-stage model of community readiness was eventually devised. The model begins with a stage of *community tolerance* that suggests that the behavior of interest (e.g., youth drug abuse) is normative and accepted. A *denial* stage involves the belief that the problem does not exist or that change is impossible. A *vague awareness* stage involves recognition of the problem, but no motivation for action to change it. The *preplanning* stage indicates recognition of a problem and agreement that something needs to be done. The *preparation* stage involves active planning. The *initiation* stage involves implementation of a program. The *institutionalization* stage indicates that one or two programs are operating and are stable. The *confirmation/expansion* stage involves recognition of program limitations and attempts to improve existing programs. Finally, the *professionalization* stage is marked by sophistication, training, and effective evaluation (see Table 5.1 for expanded descriptions).

Table 5.1. Stages in community readiness

Stage	Description
1.Community tolerance	The behavior, when occurring in a particular social context, is tolerated by community leadership; "It's just the way things are" is a prevailing sentiment. (In this instance, the "leadership" can include anyone in the community who is appointed to a leadership position or is influential in community affairs, e.g., an individual, a parent, a child, a teacher, a clergy person.) Community climate may encourage the behavior; the behavior may be expected of one group and not another (e.g., tolerance varies according to gender, race, social class, age).

2. Denial	There is usually some recognition by community leadership that the behavior itself is or can be a problem, but there is little or no recognition that this might be a local problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "We can't do anything about it." Community climate tends to match the attitudes of leaders and may be passive, guarded, or apathetic.
3. Vague awareness	There is a general feeling among community leaders that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotypical, vague, or both. No identifiable leadership exists, or leadership lacks the energy or motivation for dealing with this problem. Community climate does not serve to motivate leaders.
4. Preplanning	There is clear recognition on the part of at least some community leaders that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate may or may not support leadership efforts to deal with the problem.
5. Preparation	Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data. Leadership is active and energetic. There are decisions made about what will be done and who will do it. Resources (people, money, time, space, etc.) are actively sought or have been committed. Community climate may or may not support these efforts.
6. Initiation	Enough information is available to justify prevention activities, actions, or policies. An activity or action has been started and is under way, but it is still viewed as a new effort. Staff is in

	training or has just finished training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate may or may not support these efforts.
7. Institutionalization	One or two programs or activities are running, supported by administrators or community decision-makers. Programs, activities, or policies are viewed as permanent. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest a need for change. There may or may not be some form of routine tracking of prevalence. There may be some criticism, but community climate generally supports what is occurring.
8. Confirmation/ expansion	There are standard programs, activities, and policies in place, and authorities or community decision-makers support expanding or improving programs. Original efforts have been evaluated and modified, and new efforts are being planned or tried in order to reach more people, those who are more at risk, or those of different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on the extent of local problems, and efforts are made to assess risk factors and causes of the problem. The community climate may challenge specific programs, but it is fundamentally supportive.
9. Professionalization	Detailed and sophisticated knowledge of prevalence, risk factors, and causes of the problem exists. Some efforts may be aimed at general populations, while others are targeted at specific risk factors, high-risk groups, or both. Highly trained staff are running programs or activities, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies, or activities. The community climate should challenge specific programs, but it is fundamentally supportive.

Each stage of community readiness is a qualitative description based on information about a specific dimension. To determine the appropriate stage of community readiness for prevention, questions were centered on six dimensions that were identified using an anchor rating technique (Smith & Kendall, 1983). Anchor rating uses experts who develop statements that describe stages in a process (see detailed description of development of anchored statements in Oetting et al., 1995).

The original five dimensions found to be pertinent to assessing community readiness were (1) prevention programming, (2) knowledge about prevention programs, (3) leadership and community involvement, (4) knowledge about the problem, and (5) funding for prevention. These dimensions have since been relabeled to (1) existing prevention efforts, (2) community knowledge of programming, (3) leadership, (4) knowledge about the problem and (5) resources for prevention. The reasons for the relabeling are varied. The first four dimensions were relabeled in an effort to better define and clarify the dimension. The fifth dimension was relabeled because the Community Team of the Tri-Ethnic Center has observed in its workshops and follow ups with communities, that in order to sustain prevention efforts and integrate them into the community, it is more effective to rely on local resources (people, money, time, and space) than to become dependent on outside funding. Outside sources of support will usually be time-limited and reliance on them too often results in the effort disappearing altogether when that external funding (e.g., grants) ends. Experience in implementing the model also suggested the need for renaming the initial five dimensions and adding another dimension—community climate. (The titles, questions, and anchors for each of the six dimensions are presented in Tables 5.3 through 5.8.)

Community Climate

Community climate is a critical dimension to be considered when assessing a community's readiness for prevention. Even when there are efforts by individuals and organizations interested in or actually implementing efforts in prevention, the overall community climate may remain either highly tolerant of the problem or relatively passive and watchful during the initiation of a prevention effort. This circumstance greatly impedes prevention work.

After the publication of the Oetting et al. (1995) paper on Community Readiness, further work showed that, while community climate was a determinant of readiness at the tolerance and denial stages, at higher stages, up until the *institutionalization* stage, the overall community climate could be independent of readiness to implement prevention efforts. For example, it was possible to have a relatively high level of readiness on the part of key community leaders who were planning and even coordinating prevention efforts, while having very low levels of support by members of the community at large. It is nonetheless important to consider community climate and initiate efforts to engage the community, which improves the potential for successful intervention. Though community climate had been incorporated into the other measures in previous studies, this dimension has since emerged as a very important and singular factor integral to the assessment of community readiness. Assessment of the stages was found to be highly dependent on community climate. Adding this dimension provided for a more comprehensive and accurate picture of the community and its willingness to accept and implement prevention strategies.

For example, a low level of community readiness, exhibited by *tolerance or denial*, indicates an environment where few effective programs exist. This is consistent with the community climate that indicates that the community would be very unlikely to accept or utilize any new intervention that would be introduced anyway. Under these circumstances, the interventions must accommodate both the readiness and the cli-

mate of the community in order to gain involvement and support. If, on the other hand, the level of readiness is high among leaders but low in the community at large, while there could be established programs, activities, or policies, the community would only tolerate this activity and would lend but little involvement. This is important and suggests that the community climate needs to be improved for prevention efforts to effectively reach and involve the community and successfully impact the problem. However, if prevention efforts are in place and operating, they should not be reduced because of a lack of overall community involvement; rather, interventions appropriate to alter the community climate should be included. It is important to note that poor community climate can prevent movement to a higher stage of readiness. For example, in rural towns there may be drug prevention programs operating in the schools, but there may not be an alcohol prevention program because alcohol use is highly tolerated by the community. In rural towns in tobacco-raising country, there may be drug prevention programs, but no tobacco cessation or prevention programs. Effective prevention must change community norms—an action that must have community involvement. Assessment of community climate is essential in developing strategies for effective prevention.

Assessing Community Readiness

In a community, drug and alcohol abuse consequences can include birth defects; violence directed at intimate partners; child abuse and neglect; increased diabetes, cardiovascular diseases, carcinomas, and liver diseases; property damage; injuries and fatalities involving drug- or alcohol-impaired persons; criminal activity; lost productivity and on-the-job problems; and higher emotional distress from living with someone who is addicted. With so many systems in a community being affected by such a variety of consequences, it is highly unlikely that any one organization or person will have the complete picture. Therefore, a true depiction of the community is not possible

without some framework into which the components can be brought together to put the picture into perspective. The most appropriate method found for assessing the community's level of readiness is a survey of key informants, since the planning, funding, and implementation of prevention programs often lies in the hands of community leaders, and because those people are the ones most likely to know what is happening in their community. This assumption is supported by information gained from participants in the workshops conducted by the Community Team. The key informant survey obtains factual information from community leaders or professionals who would logically be able to provide the data necessary to assess community readiness. The key informants should be selected from among community members who would know about the type of problem examined and about that problem's existing prevention programs. They would be in touch with various segments of community leadership, and would themselves be leaders or professionals working in the community on a day-to-day basis. Usually three to five interviews are sufficient to gather the needed information. If inconsistencies are found in the interview data, more interviews should be conducted until a consensus is obtained. It is suggested that those selected for key informant interviews include representatives of the following groups: school drug and alcohol counselors, community agency representatives, law enforcement representatives, community government officials, tribal representatives, older youth, and/or a media representative.

Key informants are surveyed through semistructured interview questions (see Table 5.2). Interviewers should be skilled, and, prior to beginning the interviews, should develop an in-depth understanding of the stages of community readiness for prevention, of the dimensions, and of how the anchor statements relate to the stages. Interviewers should have sufficient practice in making reliable ratings for the six dimensions. Interviews can be conducted in person or by telephone. The questions related to the six dimensions serve as a format, and the interviewer begins by asking these questions. It may not be necessary to ask every question, or the interviewer may add related questions to get

Table 5.2. Key informant interview questions

These are the questions to be asked to assist in measuring for each of the following six dimensions:

A. Existing Prevention Efforts (programs, activities, policies, etc.)
B. Community Knowledge about Prevention
C. Leadership (includes appointed leaders and influential community members)
D. Community Climate
E. Knowledge about the Problem
F. Resources for Prevention Efforts (people, money, time, space, etc.)

The letters in parentheses indicate the dimension(s) to which the question is generally related.

A and B. Prevention Programming and Community Knowledge about Prevention

1. Does the community see (the issue) as a problem? (B and E)
2. Are there efforts addressing (the issue) in your community? (A)
3. Are the people in the community aware of these efforts? (B)
4. How long have these efforts been going on in your community? (A)
5. What are the strengths and weaknesses of these efforts? (A)
6. How are these efforts viewed by the community? (B)
7. How much do the leaders, groups, or committees in your community know about these efforts? (B)
8. Are there segments of the community in which these efforts do not apply? (A)
   Prompt: segments, for example, include age, religion, ethnicity, gender, or socioeconomic status.
9. Is there a need to expand these services? If no, why not? (A)
10. Are there plans to expand or develop other efforts? If yes, what are the plans? (A)
11. What types of policies and practices (rules and regulations) related to (the issue) are in place in your community? (A)
    Prompt: formal practices include police arresting the offender.
12. Are the people in your community aware of these policies? (B)
13. Are there informal practices, policies, or rules that are in place in your community? (A)
    Prompt: informal practices include police possibly not responding in certain areas.

Table 5.2. (Continued)

14. How long have these policies been operating in your community? (A)
15. Are there segments of the community to which these policies do not apply? (A)
    Prompt: segments, for example, include age, religion, ethnicity, gender, or socioeconomic status.
16. Is there a need to expand these policies? If no, why not? (A)
17. Are there plans to expand the policies? If yes, what are the plans? (A)
18. How are these policies viewed by the community? (B)

C. Leadership ("Leadership" can include anyone in the community who is appointed to a leadership position or is influential in community affairs, i.e., an individual, a parent, a child, a teacher, a clergy person, etc.)

19. Who, in your opinion, are the leaders, formal or informal, in your community? (C)
    Prompt: people whose opinions are respected or who are influential, and who may be contacted informally when issues arise.
20. If informal, how did they become the "leaders"? (C)
21. Does the leadership see (the issue) as a problem? (C)
22. Are the "leaders" in your community involved in prevention efforts? Please list. (C)
23. Would the leadership support prevention efforts? (C)

D. Community Climate

24. What is the general attitude about (the issue) in your community? (D)
25. Is there ever a time when, or circumstance in which, members of your community might think this (issue) is tolerated? (D)
    Prompt: circumstances, for example, include age, religion, ethnicity, gender, or socioeconomic status.
26. Would the community support prevention efforts? If yes, how? (D)
27. What are the primary obstacles to prevention efforts in your community? (D)
    Prompt: obstacles can be people, groups, organizations, attitudes, or resources.
28. Is there a sense of apathy or hopelessness among community members regarding (the issue)? (D)

Table 5.2. (Continued)

E. Knowledge About the Problem

29. Is there any information about how often (the issue) occurs in your community? If yes, from whom? (E)
30. How do people obtain information in your community? (E)
31. What types of data are available on (the issue)? (E)

F. Resources for Prevention Efforts

32. Who would a victim of (the issue) turn to first? (F)
33. Who provides resources for these efforts and how long will they last? (F)
34. What is the community's attitude about supporting prevention efforts with people, money, time, or space? (F)
35. Do people in your community know what it takes to run these programs or activities? (F)
36. Are you aware of any proposals or action plans that have been written to address (the issue's) prevention? (F)
37. What is the level of expertise and training among those working toward prevention of (the issue)? (F)

Additional Questions To Be Asked If Programs or Policies Are in Place

38. Are you aware if there are any efforts being made to evaluate the prevention efforts or policies that are in place? (A and B)
39. Are the evaluation results being used to make changes in programs, activities, or policies, or to start new ones? (A and B)

The following questions are optional, if you choose to track personal data on the respondents.

What is your age range: (list groupings)

- 19–24
- 25–34
- 35–44
- 45–54
- 55–64

What is your ethnicity?

Your position?

How long have you lived in the community?

May I have your mailing address?

That's all of the questions. Do you have other comments to add or questions you'd like to ask?

Thank you so much for your time.

more specific about an issue. Some minor modifications may be needed to the questions in order to align them to the issue under analysis; more extensive modification may be needed for the policy-related questions. Some issues may lack written formal or informal policy, making this section less applicable to the issue of focus. The interviewer takes detailed notes on each response. When the interviewer believes the questions have all been answered as best as possible, the result should be a qualitative description of what is actually occurring in that community. Immediately after each interview, the interviewer or rater should write a brief statement summarizing the information related to each specific dimension. He or she then gives a numerical rating (1–10) for each of the six anchored scales (see Tables 5.3 through 5.8 for the anchored rating scales) for using the graphic continuum for each dimension. It is often helpful to have two or more interviewers who can later discuss the information and gain a general consensus of the interview information. After the anchored ratings and statements have been completed, the interviewer then turns to the descriptions of the stages of community readiness and assigns a stage ranking to the community. That assignment should not be made simply on the basis of average numerical ratings on the dimensions, but rather should be an qualitative expert judgment based on all of the interview information and the scores on the anchored rating scales. The stage of readiness, with the descriptive material, provides an adequate description of the community's level of readiness for prevention.

It should be pointed out that the interviewers need to be patient since the length of each interview is approximately 25 to 30 minutes. Often many callbacks are required to simply reach the key informants when they have enough time to talk. The average length of time to complete two key informant interviews in a single, small community in one study was approximately 5 weeks, from initial contact to completion of the actual interview. Those with experience or knowledge of substance abuse conduct interviews most effectively. Many respondents use terminology common among treatment and prevention providers, and interviewers familiar with those nomenclatures communicated more easily and effectively.

Table 5.3. Dimension A: Existing prevention efforts (programs, activities, policies, etc.)

Descriptive Statement:

1. Prevention is not important.
2. No plans for prevention are likely in the near future.
3. There aren't any immediate plans, but we will probably do something sometime.
4. There have been community meetings or staff meetings, but no final decisions have been made about what we might do.
5. One or more programs or activities are being planned or changes in policies are being considered and, where needed, staff are being selected and trained.
6. One or more prevention programs, activities, or policies are being tried out now.
7. One or two efforts have been running for several years and are fully expected to run indefinitely; no specific planning for anything else.
8. Several different programs, activities, and policies are in place, covering different age groups and reaching a wide range of people. New programs or efforts are being developed based on evaluation data.
9. Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Practical Application of the Community Readiness Model

Many respondents have reported that the assessment process itself has proven to be an effective intervention in their communities. They have indicated that answering the questions has made them think about pertinent issues and generated discussion with peers about what should be happening in their community. Even this very basic interaction has resulted in com-

Table 5.4. Dimension B: Community knowledge about prevention

Descriptive Statement:

1. Community has no concept about what prevention is.
2. Community has no knowledge about prevention programs, activities, or policies.
3. Heard about community prevention efforts, but no real information about what is done or how it is done.
4. Some leaders, groups, or committees in the community are beginning to seek information about existing prevention programs, activities, or policies.
5. Some leaders, groups, or committees have general knowledge about programs or activities and whom they would affect. (Who would do what and for whom.)
6. A group or groups have general knowledge about local efforts and may be complacent about local efforts regardless of their effectiveness and without supporting data.
7. There is evidence that a group or groups have specific knowledge of local efforts including contact persons, training of staff, clients involved, etc., but there is a minimally perceived need for expansion.
8. There is considerable community knowledge about a variety of different community prevention efforts, as well as supporting data related to the level of program effectiveness.
9. Community has accurate knowledge based on thorough evaluation data about how well the different local efforts are working, and on their benefits and limitations.

munity change and strategy development. However, the Community Readiness Model was developed to be used as a tool to help communities more systematically assess their local situation so that they could then identify effective strategies to propel their prevention initiatives. The interventions suggested below are by no means comprehensive nor have they been rigorously tested. They have been, however, utilized effectively by communities at their respective stages of readiness. The strate-

Table 5.5. Dimension C: Leadership
(includes appointed leaders and influential community members)

Descriptive Statement:

1. Leadership resistant to prevention efforts.
2. Leadership passive, apathetic, or guarded.
3. People have talked about doing something, but so far there isn't anyone who has really "taken charge." There may be a few concerned people, but they are not influential.
4. There are identifiable leaders who are trying to get something started, and a meeting or two may have been held to discuss problems.
5. Leaders and others have been identified; a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.
6. Leaders are involved in programs or activities and may be enthusiastic because they are not yet aware of limitations or problems.
7. Authorities and political leaders are solid supporters of continuing basic efforts.
8. Leaders support multiple efforts. Authorities, program staff, and community groups are all supportive of extending efforts.
9. Authorities support multiple efforts, staff is highly trained, community leaders and volunteers are involved, and an independent evaluation team is functioning.

gies associated with the first four stages (*tolerance* through *preplanning*) are generally aimed at raising awareness that a problem may exist and working more individually or in small groups to facilitate change. Home visits to discuss the issues, small sewing groups, discussion circles, and one-on-one phone calls have been used effectively by some communities that self-assessed at this stage. At the *denial* stage, the focus is on creating awareness that the problem exists in this community. At this stage, personalized case reports and critical incidents are likely to have more impact than presenting general statistics or data. Media reports, presentations to community groups, and

Table 5.6. Dimension D: Community climate

Descriptive Statement:

1. The community does not see this behavior as a problem. It is an accepted part of community life: "it's just the way things are."
2. There is little or no recognition that this is a community problem; the prevailing attitudes are "there's nothing we can do" or "only 'those' people do that."
3. Community climate may not support, but would not block, prevention efforts.
4. Leadership may be functioning independently of the community climate during *preplanning, preparation,* or *initiation* stages of programs, activities, or policies. The community in general may or may not be involved in these efforts.
5. The majority of the community generally accepts programs, activities, or policies. Support may be somewhat passive.
6. Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for prevention. Participation level is high.
7. All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

similar educational interventions can focus on the general problem in similar communities, but these aids must bring the incidents home to the specific community, to create awareness that there is also a local problem. At the *vague awareness* stage, communities could utilize small group events, potlucks or potlatches, and newspaper editorials or articles. Although use of national or regional data may be meaningless to community residents, local survey data (i.e., school or phone surveys) may be of value. It should be noted that at this stage of readiness, school officials and parents may still be somewhat resistant to initiating these types of prevention activities; however, they should still be encouraged to do so for the growth of the community. During the *preplanning* stage, communities start gath-

Table 5.7. Dimension E: Knowledge about the problem

Descriptive Statement:

1. Not viewed as a problem.
2. No knowledge about the problem.
3. Some people here may have this problem, but no immediate motivation to do anything about it.
4. There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.
5. General information on local problem is available, but is not based on formally collected data.
6. Leaders have enough information about the problem to justify doing something.
7. Detailed information about local prevalence may be available and people know where to get specific information.
8. There is considerable specific knowledge about prevalence and causes, risk factors, and consequences.
9. Specific information about the problem is being used to target high-risk groups and plan the types of prevention programs needed. Information about the effectiveness of local programs is available.

ering information on effective prevention programming, examining pre-existing curricula and educational materials that are culturally relevant, making efforts to involve key people in the community in the planning process, conducting local focus groups or small public forums to discuss the issues, and increasing media exposure.

The stages of *preparation* and *initiation* are generally aimed at gathering and providing community-specific information to the general public. For instance, at the *preparation* stage, it is suggested that a valid and reliable school drug and alcohol survey be initiated in an effort to obtain accurate local data. Community telephone surveys could be initiated to gain information about community attitudes and beliefs related to drug

Table 5.8. Dimension F: Resources for prevention (people, money, time, space, etc.)

Descriptive Statement:

1. There is no need for resources to deal with this problem.
2. There is the belief that there are no resources available for prevention or that barriers seem insurmountable.
3. It might be possible to initiate prevention efforts, but there is uncertainty about how much it would take and about where the resources would come from.
4. A committee or person is finding out what might be needed for a prevention effort and is considering how the resources might be found.
5. It is known what is needed to staff and run a program or activity. A proposal has been prepared, submitted, and may have been approved. The people who will be involved have agreed to participate.
6. Resources are available, but they are only from grant funds, outside funds, or a specific one-time donation, or the resources are volunteers who are running a program or activity, which is temporary.
7. A considerable part of the support of ongoing efforts is from local sources that are expected to provide indefinite and continuous support.
8. More than one program, activity, or prevention policy is in place and is expected to be permanent, and there is some additional support for further prevention efforts.
9. There is continuous and secure support for basic programs and activities, evaluations are routinely expected and completed, and there are substantial resources for trying new efforts.

and alcohol use. More in-depth local statistics should be gathered, more diverse focus groups should be held to gain a wider representation of the community and develop practical strategies for prevention efforts, and grant development could start. At the *initiation* stage, interventions might consist of conducting training for professionals and paraprofessionals, conducting consumer interviews to gain information about improving services, identifying service gaps, and identifying potential

funding sources that match community needs through accessing computers.

The final three stages—*institutionalization*, *confirmation/expansion*, and *professionalization*—are more programmatic in nature and aim toward evaluation of efforts and making program modifications based on those evaluations. During the *institutionalization* stage, basic evaluation techniques are initiated in an effort to modify and improve services. In addition, in-service training is provided to increase the number and quality of trained community professionals, community events aimed at encouraging a drug-free lifestyle are planned, community volunteers recognized, and community workshops conducted. The *confirmation/expansion* stage involves the same kinds of activities, occurring at a higher level of sophistication. External evaluation services obtain a more comprehensive community data base, activities that change local community policies and norms are initiated, media outreach provides information about local programs and reports local data trends, and the ongoing community focus groups and public forms maintain grassroots involvement. At the final stage, *professionalization*, activities consist of a very high level of data collection and analyses, of sophisticated media tracking of trends, of requests to local businesses to sponsor community-wide events, and of diversifying funding resources.

It is very important to pay close attention to the stage of readiness so that the type of the intervention is appropriate to the stage. For example, a community in the *denial* stage is not ready to conduct a focus group aimed at developing strategies for intervention. Likewise, a community at the *tolerance* level would not attend a drug-free community event. It is important at all stages to continue monitoring the level of community readiness. Often events occur that may force a community to fall back to a lower stage of readiness. This could occur as a result of changes in tribal or community administration, changes in population, policy changes, changes in law enforcement, or other changes. Yet, communities report that when this type of event occurs, they re-assess and adapt interventions and continue efforts until they reach the desired stage of readiness.

The purpose of this chapter was to present the Community Readiness Model, describe the development of the scales and their utility in the area of drug and alcohol prevention, and offer interventions that have been found anecdotally to be effective at the various stages. However, it was discovered that the Community Readiness Model has the capacity to be used in arenas other than drug and alcohol use prevention, given slight modification to the questions the Model poses to participants.

The Application of the Community Readiness for Prevention Model for Other Health and Social Issues

In March of 1995, the Center's Community Team was invited to speak at a meeting of two Western regional tribes and their leaders. The tribes had experienced a great deal of environmental distress due to radiation poisoning and uranium dust contamination. The communities had to deal with grief due to the loss of many tribal members to cancer and from the other health consequences resulting from exposure to deadly substances. Further, because of the environmental destruction, many of the tribes' traditional plant and animal medicines were gone. They wanted to bring the communities together to reduce further threat and implement preventative and early cancer-detection mechanisms. They had tried other strategies but were unable to get anything started. A foundation based in the Eastern United States had heard of the community readiness work conducted by the Community Team and requested that it make a presentation to the tribal leaders. Although the team was somewhat reluctant to introduce the Community Readiness Model into a topic area other than drug and alcohol prevention, because of its ties to the Native community the team decided to introduce the theory and work with the participants to adapt the model to the situation.

The tribal members had no difficulty adapting the Model to their needs. They were able to classify each community at a specific stage of readiness. They used that information to develop a

step-by-step action plan. The group decided to make personal home visits to educate people in the community in an effort to develop community support for the programs and move beyond the immobilization created by grief. Community members visited then became part of the group, began visiting others, and momentum grew quite quickly. Once the community moved to the next level of community readiness, small informal focus groups were held to determine what nature the intervention should assume, e.g., pot lucks, public forums, visits to churches and tribal gatherings, and so forth. The groups decided to take several different directions and divided up the tasks.

The group has now established mobile mammogram vans at the high school and at smaller clinics and has provided all members of the community with early detection materials and contacts for available resources. The group continues to call the Community Team from time to time; it reports that it is still moving ahead and, further, that when it does get stuck, it reassesses the situation using the Community Readiness Model to identify the obstacles, and then goes from there.

The Center recently received a grant from the Centers for Disease Control and Prevention (CDC) to adapt the Community Readiness Model to the prevention of intimate-partner violence in rural communities. Early findings indicate that the model is viable for this effort as well. The Community Readiness Model dimensions, factors, and interview questions were adapted to address the issue of intimate-partner violence in rural communities. Following the adaptation of the interview questions and scales, the focus groups attempted to obtain further knowledge about both formal and informal community resources, as well as about community, cultural, and regional factors that may have either positively or negatively affected tolerance, acknowledgment, reporting, intervention, and prevention of intimate-partner violence. The next stage, currently in progress, in the project is to conduct individual interviews with women from the communities to get more in-depth information regarding the communities' attitudes and practices regarding intimate-partner violence. The final stage will be to

develop and test culturally appropriate strategies to help rural communities to increase community readiness for the prevention of intimate-partner violence. These experiences suggest that the basic Community Readiness Model is easily adaptable to other situations.

Conclusions

Many of the communities our Center staff has worked with have maintained contact and allowed follow-up on activities since the introduction of community readiness theory and prevention planning based on the theory. Most communities have moved forward toward either receiving funding or modifying applications to continue to seek funding to implement their prevention plans and strategies. Some communities have chosen not to utilize funding, but rather to engage the community in volunteer action. For those communities that have not moved forward, the reasons are varied, but a consistent theme has been either political change within the tribes and villages or personnel changes. For some, a critical community crisis has occurred that has taken the focus away from drug use prevention issues.

Although the Community Readiness Model was developed specifically for alcohol and drug abuse prevention, it was created with a broader aim of assessing readiness for a gamut of problems. These range from health and nutrition issues (such as sexually transmitted diseases, heart disease, and diet), to environmental issues (such as water and air quality, and litter and recycling), social issues (such as poverty and homelessness, drug abuse, and violence), and personal problems (such as depression and suicide). The model can therefore be applied to many kinds of community-based prevention initiatives.

Finally, effective community prevention must be based on multiple systems and utilize community resources and strengths. It must be culturally relevant and geared toward the long term. Community readiness takes these factors into account, and there-

fore it increases the potential for programs to be cost-effective, and to be focused and directed toward the desired result.

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6

Native American Perceptions of the National Association for Native American Children of Alcoholics: In Their Own Words

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Abstract

This chapter describes a national programmatic response for the prevention of alcohol and drug abuse in Native Americans. We describe a comprehensive and culturally congruent evaluation of the prevention efforts and programs developed by the National Association for Native American Children of Alcoholics (NANACOA).

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In 1995 and 1996, NANACOA convened a team of professionals to conduct an evaluation of the organization's programs. In convening the evaluation team, NANACOA's goal was to recruit individuals whose expertise included familiarity with substance abuse issues, preventative interventions, and program evaluation. Moreover, NANACOA sought to ensure that the evaluation team had intimate knowledge of and experience with the conduct of evaluation research in Native American communities. To characterize the nature of NANACOA's unique mission of hope and well-being for Native American people, the team developed a culturally congruent approach to evaluation in order to assess the progress in meeting NANACOA's commitment to the "recovery of the human being" and "the healing journey."

Supported and encouraged by the Center for Substance Abuse Prevention (CSAP), the National Association for Native American Children of Alcoholics (NANACOA) initiated a strategy in 1995 to evaluate their programs and prevention efforts. This strategy first involved organizing the available literature to identify factors that are of concern to American Indian and Alaska Native communities. Understanding the particular patterns of risk provides a basis for assessing and evaluating specific prevention service needs in American Indian and Alaska Native communities. Data from the program evaluation, along with an understanding of risk for drug and alcohol abuse, can enable limited prevention resources to be devoted where they are likely to achieve the greatest benefit. NANACOA believed that these evaluation results could assist in increasing our understanding of community-based prevention strategies and activities and aid decision making in policy and program planning ventures.

This chapter details the development and implementation of the NANACOA evaluation that occurred over a 1-year period. As the evaluation of NANACOA evolved, it became clear to the evaluation team that NANACOA is an organization that was built around the needs of Native Americans who have lived with alcohol and drug abuse for generations. Native Americans' concerns, needs, and experiences are not static—they change

with each successive generation. As NANACOA has responded to Native Americans' changing needs, a transactional relationship has developed between NANACOA and Native American communities, and this transactional relationship in turn served as the cornerstone for the evaluation of NANACOA.

The transactional relationship between NANACOA and its constituency was assessed through a three-pronged evaluation approach that used separate data sources to capture the voices and stories of Native Americans as they talked about their families, their communities, their hopes, and their dreams. Through well-established qualitative research techniques, the words of Native Americans, taken from personal interviews, focus groups, and archival data, were recorded and analyzed. An important part of the evaluation were focus groups and personal interviews designed to elicit the stories of individuals, their communities, and their visions of the future.

An Overview of American Indian and Alaska Native Drug and Alcohol Use Problems

Now, and for many prior decades, drug and alcohol use and abuse has continued to occur in American Indian and Alaska Native communities, and the patterns of use and abuse appear to consume all but a few of those communities. Along with the frustration, pain, and senseless deaths that result from drug and alcohol abuse, American Indian and Alaska Native communities must struggle with treating and preventing a problem that does not seem to fit within their own traditional healing systems. The anger and frustration engendered by the presence of psychoactive substances is intensified by the cultural assumption that prevention and treatment strategies are usually not effective in general. Since many theoretically based prevention strategies appear to be designed for use with the dominant culture, the prognosis for creating drug-free communities in diverse and culturally unique settings appears grim.

These pessimistic feelings and perceptions of American Indians and Alaska Natives are not unfounded. Available evidence exists that substantiates and validates their myriad concerns and sentiments. For example, substance use rates for American Indian students have paralleled the rates of non-Indian students over the past 20 years. There was a pattern of large increases in the late 1970s, a leveling off in the 1980s, and modest declines in the 1990s (U.S. Department of Health and Human Services, 1995). However, recent evidence shows that the rates in some areas are climbing upward once again (Beauvais, 1996). Lifetime prevalence rates of alcohol, cigarettes, illicit, and nonmedical use of licit psychoactive drugs among American Indian high school seniors were compared with non-Indian seniors (Johnston, O'Malley, & Bachman, 1995). Results showed that American Indian high school seniors had higher lifetime and past-month prevalence rates than non-Indian youth for most substances surveyed. Segal (1992) points out that the drug and alcohol use prevalence rates in certain Alaska Native villages are quite high and in a few instances reach epidemic-like levels. Beauvais, Oetting, Wolf, and Edwards (1989) found that American Indian youth in rural areas have higher drug use rates than non-Indian youth for nearly all drugs. In a more recent study, Beauvais (1992) compared drug use rates among American Indian youth living on reservations and those who reside in nonreservation (mostly urban) areas. On all indices of drug use and other forms of deviance, the reservation youth reported higher rates.

Longitudinal and cross-sectional studies of drug use patterns among American Indian and Alaska Native adults are almost nonexistent in the literature; there appears to be much more data available for adolescents. Oetting, Edwards, and Beauvais (1989) have been assessing and evaluating drug and alcohol use among samples of American Indian youth largely from reservation communities in the Western States since 1974. Oetting et al. (1989) compared their drug use rates with comparison data from the National Household Survey. Overall, the American Indian use rates were much higher than those of non-Indian youth. To account for some of these findings, Oetting et

al. (1989) observed that much of "the anti-drug publicity has been aimed generally at the 'good kids' and it seems to have influenced them. But anti-drug efforts have apparently not been able to reach those young American Indians who have a high potential for deviance" (p. 13). Youths at highest risk, who reportedly use drugs with some regularity, account for approximately 20% of these American Indian youth. Data generated from these longitudinal surveys are consistent with other short-term studies on American Indian drug use. May (1982) showed that overall American Indian youth use rates exceed those of the general population. Weibel-Orlando (1984) reinforced May's findings, adding that "there is overwhelming evidence of the profound effects early drug socialization...has on individual drinking and drug use patterns (among American Indians)" (p. 329).

Studies conducted among American Indians and Alaska Natives in the Pacific Northwest and Alaska reveal similar use rates to those previously reported. Survey data generated from American Indian youth in rural areas of Washington State showed that at least 20 percent of them reported using marijuana, tobacco, and inhalants and that more than half of these youth have tried alcohol (Gilchrist, Schinke, Trimble, and Cvetkovich, 1987). Researchers in Washington State have been involved in a large-scale, longitudinal, urban-based study of alcohol and drug use among cohorts of American Indian youth and their parents (Walker, Lambert, Walker, Kivlahan, Donovan, & Howard, 1996). Results from this study indicate that as American Indian youth mature from early to late adolescence, there is a steady increase in lifetime, annual, and 30-day prevalence of drug and alcohol use rates. A comprehensive survey of drug use administered to a sample of more than 4,000 Alaskan youth found that Alaska Native and American Indian youth showed higher drug and alcohol use than other youths (Segal, 1989). In comparing results from two other longitudinal surveys of Alaska Natives, it is clear that drug use among Alaska Natives is fairly high (Segal, 1983; 1988). Segal (1988) summarized, "the changes within the (Alaskan) regions suggest that while there is *general consistency* (our emphasis) across regions

concerning use of some substances, there are also some patterns idiosyncratic to different locations" (p. 95). Considering the expansiveness of Alaska and remoteness of most of the Alaska Native communities, Segal's findings are alarming; how do drugs find their way into these small, remote communities?

The National Association for Native American Children of Alcoholics

The founding of the National Association for Native American Children of Alcoholics (NANACOA) was stimulated by the abundance of personal testimony and professional research that alcohol and drug use and abuse are major health problems with American Indians and Alaska Natives: problems that sometimes reach epidemic proportions in many of their communities. Founded in 1988, NANACOA has a vision to heal the suffering among Native American people caused by generations of substance abuse and chemical dependency. Through a message of hope, NANACOA believes that Native Americans could undertake this challenge themselves. Emphasizing a belief in the Creator and a healing journey from the destruction of alcoholism, NANACOA began their work. The increasing membership growth of NANACOA serves as a testament to the importance of their mission. At their first conference, more than 700 individuals registered. Each subsequent conference has attracted more than 1,000 people.

NANACOA's present work centers on a unique model of intensive training that helps individuals take the next step in their personal healing journey while building a community of safety and with the support with others. As an integral part of the healing movement in Native communities today, this next step focuses on care, resiliency, sharing, prayer, and song, while providing information on alcoholic families, trauma, and the healing process. NANACOA has sponsored many intensive training programs in American Indian communities around the country, supported annual conferences, produced several publications and videos, and cooperated and collaborated actively

with other national and international substance-abuse prevention programs. By joining together, NANACOA members find the resources, support, and strength needed for a healing journey dedicated to health and well being for Native American families, communities, and nations. In a spirit of healing and recovery, NANACOA's stated objectives are to (1) establish a national network for Native American children of alcoholics; (2) develop educational and support information for Native American communities; (3) hold national conferences for Native American children of alcoholics and others working in Native communities to come together to heal and recharge energies; and (4) inform local and national policy makers about the needs of Native American children of alcoholics and influence positive change toward creating healthy communities.

Methodology

Cultural Considerations

For a number of years, there has been considerable concern expressed in Indian Country on the use of conventional evaluation research techniques. Past evaluation efforts, particularly those that failed to respond to the cultural demands of research in Native American communities, have yielded information that has been of dubious value in helping Native American people develop practical approaches to solving actual problems. At a fundamental level, exclusive reliance on quantitative techniques may be considered too reductionistic to adequately portray American Indian realities in a manner meaningful to American Indians. That is, if the purpose of research is expected to be useful to an American Indian community, that research must reflect the values, beliefs and other epistemological assumptions of the American Indian community. The research should also respect the wide range of linguistic, tribal, and cultural diversity in Native America.

The NANACOA evaluation project stressed collaboration between the social scientist and the American Indian commu-

nity (Beauvais and Trimble, 1992; Shore and Nicholls, 1977; Shore, 1989; Trimble, 1977). The design and methodology of the project incorporated a "naturalistic" approach in order to help preserve cultural integrity. Guba and Lincoln (1981) recommended using naturalistic inquiry in order to maintain the cultural integrity of the assessment process and to respect multiple perspectives. Naturalistic inquiry allows for and encourages all stakeholders in the research enterprise to tell their story. Wolf and Tymitz (1977) suggest that naturalistic inquiry is aimed at understanding the existing actualities, cultural realities, and perceptions, untainted by the obtrusiveness of formal measurement of preconceived questions. Attempting to capture the essence of naturalistic inquiry, this evaluation used semistructured interviews and focus groups. The protocols were designed to allow respondents to "tell their own story" in their own words, minimizing the bias imposed by the researchers and methodology. Although this sometimes created scheduling problems for facilitators, this "storytelling" approach served the purpose of recognizing the meaningful contributions of each respondent. Within this perspective, we considered the "stories" told by respondents to be part of the "story" of NANACOA. Thus, the evaluation was considered to be a set of linked narratives, and the narratives of each respondent become embedded within the narrative of NANACOA as an organization. Storytelling and narrative expression are basic Native American traditions, and therefore are meaningful ways to approach evaluation research in an American Indian context.

Our experiences with storytelling generated consideration of what Blumer (1969) called symbolic interaction, in which meanings in human relations are modified and negotiated through an interpretative process based on continuing interaction. The evaluation team perceived symbolic interaction as a major feature of how NANACOA organizationally perceives its relations with its constituents. Blumer (1969) described the assumptions of symbolic interaction theory in three ways: (1) human beings act toward things on the basis of the meanings those things have for them; (2) meanings are derived from the social interactions one has with one's community members;

and (3) meanings are modified through an interpretative process based on continuing action in and interaction with the social world. In listening to these stories, we acknowledged the complexities of language and culture. Paula Gunn Allen (1986) contended that allowing people to "give voice" to their life journeys allows a "holistic image to pervade and shape consciousness, thus providing a coherent and empowering matrix for action and relationship." Zemke (1990) noted that stories can play a stabilizing role in our culture and claimed that "without air our cells die, without a story our selves die." A story provides structure for our perceptions and assessments of reality. In many American Indian tribal groups, a story has a life of its own.

Evaluation Design

The evaluation used three sources of program data. The first was a content analysis of NANACOA program archival data, mostly in the form of reports and records. The second involved transcripts of a series of personal semistructured interviews. The third involved the transcripts of a set of focus group meetings. The evaluation plan was designed to be culturally congruent, somewhat structured but simultaneously open enough to allow for both anticipated and unanticipated outcomes and benefits.

Archival Data

This came from two sources: correspondence data and conference preregistration forms. The correspondence data used in this evaluation consisted of all written and phone requests for material or information from NANACOA, other than normal business correspondence, between the years 1991 and 1994. The correspondence data was arranged by year and then coded for the month and geographical area it was received, the agency and affiliation of the person making the request, and the type of material requested.

The second source of archival data was compiled from conference preregistration forms filled out by conference registrants and received by the NANACOA office before the start of each

yearly conference in 1992, 1993, and 1994. Questions on these forms asked about demographics such as age, education, and employment. Conference attendees who registered on-site were not included in this database because on-site registrants did not complete a preregistration form.

Personal Interviews and Focus Groups

A total of 14 focus groups and 54 individual interviews were conducted. Respondents for both the personal interviews and focus groups represented a convenience sample. The personal interviews and focus groups were completed at the NANACOA conference and in three regions of the United States (Midwest, Northeast, and Southeast). Participants at the NANACOA conference were contacted by telephone and letter from the NANACOA office. These telephone and letter requests drew from the sample of conference preregistrants. All preregistrants were eligible for inclusion in this sample; the sample from this list of preregistrants was selected based on two criteria: geographic region and age group (youth, adults, and elders). This selection rendered 137 individuals who were asked to participate. Of the 137 contacts, 86 (62.8 percent) agreed to participate in either a focus group or personal interview. Participants from the Midwest were drawn from personal contacts in the community. Participants from the Northeast and Southeast were recruited through a letter to tribes in those regions.

Personal Interview and Focus Group Questions

Both the personal interviews and the focus group sessions used a standardized protocol as a semistructured guide for facilitating dialogue. The protocol contained questions that were primarily open-ended, but included a few closed-ended items where appropriate. The content for interview and focus group questions were sampled from the following six dimensions:

1. Public awareness—about NANACOA and ACOA (Adult Children of Alcoholics) issues, and general community and

community leadership awareness of NANACOA and its mission;

2. Cultural issues—including the impact of recovery on cultural identification and the need for a national, Native American–specific prevention initiative;
3. Personal significance—such as self report of the personal impact of substance abuse and the impact of involvement with NANACOA;
4. Personal learning—assessing the need for information at the community level and motivation to learn more about substance abuse prevention, including NANACOA and its sponsored events;
5. Personal story—such as the challenges faced during the process of recovery and in becoming personally committed to prevention of substance abuse in their communities;
6. Organizational needs assessment—including knowledge of NANACOA, its activities and its mission, participation in NANACOA-sponsored activities, and involvement with other substance abuse programs.

The types of questions asked included those relevant to process, outcome, and impact of each of these six content dimensions. Process questions ask how NANACOA's message is delivered to individuals and communities. Outcome questions ask about the perceived results of involvement with NANACOA and other substance abuse prevention and recovery initiatives. Impact questions assess consequences, particularly the enduring effects of involvement with NANACOA and other prevention and recovery programs. The protocol allowed for asking these process, outcome, and impact questions in seven areas: (1) awareness of NANACOA; (2) involvement with NANACOA; (3) familiarity with substance abuse issues; (4) involvement with substance abuse organizations; (5) personal experiences with substance abuse issues; (6) community experience with substance abuse issues; and (7) organizational feedback.

Results

Personal Interviews

A total of 50 personal interviews were conducted. Thirty-five personal interviews were conducted at the 1995 NANACOA conference and 15 were conducted in various regions of the United States (7 in Kansas, 4 in New York, and 4 in Florida and South Carolina). Three of the personal interviews at the conference are not included in this analysis because the audiotapes of these interviews were inaudible. At the conference, 26 participants were recruited from the preregistrant list and 6 Native Americans volunteered to participate after an announcement was made during one of the conference sessions. The participants who attended personal interviews at the conference were 13 (41 percent) men and 19 (59 percent) women.

Responses to Dichotomous Questions in the Personal Interviews

Several of the questions in the protocol were designed to be answered either "yes" or "no" by participants. Indeed, participants in personal interviews responded to many of the questions with a "yes" or "no"; occasionally, a participant would respond "I don't know" or would give some other response. Table 6.1 shows how the 47 participants in the personal interviews responded to these questions.

Table 6.1 compares conference participants with nonconference participants on their responses to the dichotomous questions. The following percentages were calculated using the total number of responses to each question and not the total number of participants in each group. Not surprisingly, knowledge of NANACOA and NANACOA activities was more prevalent among the participants who attended the conference. Only 43 percent of the nonconference participants knew what NANACOA was, compared with 90 percent of the conference participants. Similarly, fewer nonconference participants knew about NANACOA's purpose (20 percent to 80 percent), knew what

Table 6.1. Conference and nonconference personal interview: Responses to dichotomous questions

	Conference (*n*=32)				Nonconference (*n*=15)			
	Yes	No	DK	Other	Yes	No	DK	Other
Knowledge of NANACOA:								
Do you know who NANACOA is?	28	2		1	6	8		
Do you know if tribal leadership knows about NANACOA?	21	4	7		5	6	1	
Do others in your community know about NANACOA?	21	8		1	6	4	1	
Do you know what NANACOA's purpose is?	24	6			3	4	8	
Do you know what NANACOA does?	17	14			4	10		
Have you seen NANACOA's posters in your community?	22	10			7	6	1	
Should NANACOA be a national organization?	24		1	2	10	1	1	
Participation in NANACOA:								
Have you ever participated in NANACOA activities?	18	13	1		4	7		
Has anyone in your community participated in NANACOA activities?	24	6	2		6	3	4	
Have you been involved in putting up NANACOA posters?	13	11			2	8		
Are you a member of NANACOA?	16	13	2	1	2	12		
Have you had any other kind of contact or relationship with NANACOA?	7	23			2	10		

Table 6.1. (continued)

	Conference (*n*=32)				Nonconference (*n*=15)			
	Yes	No	DK	Other	Yes	No	DK	Other
Desire for More Information:								
Would you like to become more familiar with the effects of problem drinking?	19	3		1	10	1		
Would you like more information about the kinds of groups that deal with problem drinking?	18	6	1	2	12	2		
Would you like to know more about NANACOA?	29	2			11	1		
Is there anything else that you'd like for us to know or you'd like to say?	14	4			6	4		
Would you be interested in having NANACOA sponsor some kind of activity in your community?	27				14			
Involvement with Addictions:								
Have you been involved with any other groups that deal with problem drinking?	26	5			11	3		
Personal History:								
Have drugs and/or alcohol affected you personally?	26	1			13			
Has your involvement with NANACOA made any difference in your life?	26	1	2	1	6	6		

Table 6.1. (continued)

	Conference (*n*=32)				Nonconference (*n*=15)			
	Yes	No	DK	Other	Yes	No	DK	Other
Cultural Responsiveness:								
Has your involvement with NANACOA been important to you as an Indian person?	25	3		1	9	1		1
Have any changes occurred in the way you think or feel about yourself as an Indian person because of NANACOA?	16	6		5	5	3		
Do you feel that NANACOA should be an Indian organization?	25	3			10			2
Community Impact:								
Do you feel that drug and alcohol abuse has affected your community?	32				14			
Is it important that your community has been addressing problems associated with drug and alcohol abuse?	32				12			
Has involvement with NANACOA made any difference in your community?	13	7	3	1	3	3	5	
Are there groups that deal with problem drinking available in your community?	28	1			10	1		1

Note: DK = Don't Know.

Interview participants may not have responded to every question; therefore, responses may not add to *n* for each group.

NANACOA did (29 percent compared with 55 percent) and knew about tribal leadership involvement in NANACOA (42 percent compared with 66 percent). Participation in NANACOA-related activities were more frequent among the conference participants. For instance, compared with the conference participants, fewer nonconference participants put up NANACOA posters (20 percent compared with 54 percent), or participated in NANACOA-sponsored activities (35 percent compared with 56 percent).

Despite these differences in knowledge about NANACOA or NANACOA-related activities, requests for information did not vary between the conference and nonconference participants. Both groups wanted to obtain information about problem drinking, information about therapy groups that focused on problem drinking, and information about NANACOA. Both groups of participants were equally interested in having NANACOA sponsor some kind of activity in their community. Not surprisingly, 87 percent of the conference participants stated that involvement with NANACOA made a difference in their life, contrasted with 50 percent of the nonconference participants. Additionally, only 27 percent of the nonconference participants said that NANACOA has made any difference in their community, compared with 54 percent of the conference participants. Even though the majority of nonconference participants said that they did not know about NANACOA, they (75 percent) did state that NANACOA should be an American Indian organization. The conference participants (89 percent) concurred.

Both groups of participants stated that drugs, alcohol, or both have affected them personally, and that drugs and alcohol have affected their community. Unfortunately, 39 (98 percent) participants stated that drugs, alcohol, or both have affected them. Additionally, all of the participants stated that drug and alcohol abuse has affected their community and that it is important that their community address these problems. Thirty-eight (93 percent) participants did say that groups dealing with problem drinking are available in their communities, and 37 (82 percent) stated that they had been or are currently involved with those groups. In addition, 32 (76 percent) participants indicated

that NANACOA has made a difference in their lives, and 16 (46 percent) indicated that NANACOA has made a difference in their communities. Lastly, 35 (88 percent) said that NANACOA should be a Native American organization, and 34 (85 percent) said that their involvement with NANACOA is important to them as Native Americans.

Focus Groups

A total of 12 focus groups were conducted. Eight focus groups were completed at the 1995 NANACOA conference in Spokane, Washington, one focus group was conducted in the Midwest, one was conducted in the Northeast, and two were conducted in the Southeast. The focus group that was conducted in the Northeast is not included in this analysis because the audiotape could not be transcribed due to poor sound quality. A total of 65 individuals participated in the focus groups. Forty-nine (77 percent) participants attended focus groups at the conference. The focus group participants at the conference were 17 men and 32 women. Four of the focus group participants at the conference were rovers. The gender of the focus group participants who did not attend the conference was not available. Eighteen separate focus group themes were extracted from the focus groups. We list these themes below along with excerpts from the interviews.

1. Familiarity with Problem Drinking and Drugs and Their Effects.

Every personal interview and every focus group had stories about the participants' familiarity with problem drinking or drugs. Each participant had a personal history to relate, whether it was their own or that of a family member, that emphasized the overpoweringly negative effects that substance abuse had on their life or the life of a loved one. One participant succinctly summed up his familiarity with substance abuse: "Destruction of community, family destruction." This echoes the comments of many of the participants. They talked about the many different ways they are familiar with problem drinking, whether in their own families or in their communities. One participant summed

up the range of problems that are influenced by alcohol and other drug abuse:

> *It just goes on and on really. Those are the direct things you can just pinpoint right off. But again, just the breakdown of your families and your communities and all the struggles that we go through and all of the fighting that takes place—domestic violence, neglect, just all the social problems as we call them—I think, if not actually involving alcohol and drugs, are preceded by the use of alcohol and drugs.*

There were eight themes revolving around the familiarity of problem drinking and drugs and their effects identified. The first theme, pain and loss, elicited heartbreaking testimony on the direct influence of substance abuse in the lives of our participants. This theme was divided into three subsidiary themes: the break up of families and friendships, suicide, and death. The seven remaining primary themes were substance abuse as a way of life, substance abuse as a way of escape, substance abuse leading to violence, substance abuse causing anger, the generational transmission of substance abuse, its effect on the community, and its effect on children. These themes are discussed below.

Pain and Loss. When participants were asked about their familiarity with alcohol and drug abuse, their responses were permeated by a sense of general pain and loss. Most participants stated that alcohol and drugs, in one way or another, had affected all Native Americans. Alcohol and drugs were directly responsible for the loss of many things, especially the loss of self and the loss of Native American culture.

> *I tried to hide it, but everybody knew my dad was an alcoholic. The teachers and everybody watched me like a hawk—what do you call it? High-risk behavior? And then my own drinking: I drank for, I think, 12 years. Started when I was a teenager, I quit when I was 26. At that time, I was the only one drinking in my immediate family, and, of course, that affects the whole family. They didn't know how I was going to be at any time I came home. I have two younger brothers that I took care of all*

of the time when I was a kid, and they never knew how I was going to be when I came home, or if I'd be alive, or where I was. When I got sober, I think they kind of walked around on egg shells for about 5 years because they didn't believe that I could stay that way. I had to watch my two youngest brothers go through the same thing. They're still out there, and they're still doing it, and one by one losing things; marriages, cars, drivers licenses, jail, children, and just going on and on.

Breaking Up Families/Friends. Many participants were adult children of alcoholics and were raised in families riddled by the economic and emotional problems caused by substance abuse. The participants were familiar with the effects of alcohol and drugs because of the destruction that substance use and abuse had caused in their own families and the families of friends. Many had seen the break up of their family of origin, and many more had their marriages break up because of substance abuse. In their conversations, participants talked about how their families had been overpowered by substance abuse, and how this eventually led to the breakdown of their family.

It's just overpowering sometimes to be with these people that you love and care about and see what it does to, not only our family when I was a child, but to their families now that they have children and how it's affecting them.

It's affected us for years and years. It's a cause of feuds between families because if there wouldn't have been drinking, there wouldn't have been any fights between these family members, other families against families. There's been a lot of misunderstandings over that stuff.

Suicide. Unfortunately, several participants were familiar with how substance abuse can lead to suicide or suicidal gestures. Several participants had attempted suicide themselves, and others had known a friend or a family member who had committed or attempted suicide while using substances.

Death. Death caused by substance abuse was not an uncommon experience among the participants. Many had parents who

died from alcoholism, and many more had friends or relatives killed in accidents caused by alcohol. Many participants had more than one family member or friend die of alcohol abuse; these stories were especially heartbreaking because the death of family members and friends attributable to alcohol abuse was so pervasive that it became the rule rather than the exception. While deaths due to alcohol-related injuries and problems were common, the sentiments expressed by the participants about this ranged from anger to frustration.

> *My dad was the first one to go to college in his family, and he was an incredible person. He was an All-American football player, and could have been just about anything. But he didn't know how to be a person and he died (at) a young age. I think he was 39 when he died from drinking. His sister, my aunt, followed him a few years later, died of the same thing. And there's been a lot of others. I lost another aunt, his older sister, last year. She wasn't drinking at the end, I don't think she drank in a long time, but still the ravages that it does on your body. She still died of cirrhosis, and she wasn't elderly. She was the only one in my family that danced besides me in powwows.*

Way of Life. Drinking and drug taking were sometimes described as an accepted way of life among many of the participants' family and friends. Substance abuse as a way of life occurred on weekends, during the week, with family members, with friends, and almost always involved the children of the substance abusers. Some participants expressed outrage at having lived this way; some participants were outraged at seeing children being raised in this environment. There were some participants, however, who expressed feelings of hopelessness about the situation.

> *I grew up with it. Everyone drank where I grew up. Everyone did. You know, kids, and the adults, and, I guess, growing up—that was just the way to go. There wasn't any other way. It was like, you can't wait to be 21 so I can go into bars legally even though I was already in them. That was just a way of life. When we sobered up, it's still like you kind of don't fit in. It's*

really difficult, humiliating almost. It's almost easier to just go along with the flow than to sober up.

Way to Escape. Participants discussed alcohol abuse as a way to escape the horrendous conditions they were being raised under. Other participants used alcohol to escape some emotional trauma that had just occurred.

Violence. Participants were familiar with many different types of violence that ranged from verbal violence to different variations of physical violence. It was not uncommon for the participants to have witnessed some physical violence during their life, and unfortunately, it was not uncommon for the participants to have been a victim of this violence themselves. In a few cases, participants had been involved, as perpetrator or witness, in homicide. The trauma of any type of homicidal event is long lasting. Those who had been involved in homicide, either directly or indirectly, talked about how it had changed their lives and how they have spent their lives trying to make sense out of the event. It was not uncommon for participants to be victims of physical violence, either as a child or an adult. Many had been abused as children, and several of the women had left abusive relationships. This abuse was attributable to substance abuse in the victimizer.

To me, it just made me look stupid, and I did some really stupid things. My little cousin, who's 5 now, she living with us right now, and when I was drinking, I would always go and hit her, so now she expects me to hit her.

Life experiences, problems resulting from that, all the anger that I had stuffed, I ended up killing a man, and I served a life sentence in prison. That blackout was there, but at the same time that denial of it, and when I did later on go through some healing, some ceremonies, and start having dreams about what happened and then going through some changes, I can admit now that I did kill that man. I did it in a violent way, and even though at that time I was in a blackout the fact was that now I had to take that—I have to own that responsibility that I did that.

Anger. Many participants were angry about the negative events that had taken place in their lives that could be attributable to substance abuse. Several participants also talked about how substance abuse could influence anger by heightening the angry person's responses (i.e., the person gets more angry after they drink).

Generational Transmission. Several participants considered the theme of the problem of substance abuse transmitted down through the generations. Many participants talked about the generational transmission of alcoholism as it passed down from father to son or mother to daughter. Most participants spoke about family transmission, and some participants talked about what could be termed community transmission. Community transmission refers to alcoholism or drug abuse as the norm in the community. In many communities, individuals who do not drink are treated as outcasts. The concept of community transmission is interesting, given that this concept does not generally appear in this topic's literature, and is most likely a unique Native American perspective.

> *So it's devastating, the fact that the usage starts at a young age—11,12. Often, it's a generational effect. I think it's been passed on for who knows how long. I mean, ever since it was introduced to our people. The only word is devastating—with all the loss of potential with individuals and families and communities. It's permeated really into all of our lives. When we try to interact with each other, it has an effect on us. When we try to work together as community organizations, Indian organizations, I think it affects every aspect of the life. It's just become so entrenched in the community.*

Effects on the Community. The familiarity of substance abuse problems in the community was ever present; almost all of the participants had something to say about this. The theme was consistent: alcohol and other drug-taking behavior had negatively affected the Native American community to the point of almost destroying the culture.

I live in a very small town. In fact, there's three little towns that are kind of like 7 or 8 miles apart. I live in an apartment house. I watch the kids come at noon to smoke their lunch and go back glassy eyed. It's mostly, well, no, the whole community is that way. They do a lot of drugs and a lot of drinking. It's a logging town. And so the kids don't have a chance because up here, their parents are doing it, and they are just following in their footsteps. They don't know any other way. And so, it's really the kids that I see, you know, I'm worried about them mostly, and being drunk in the evening and out after curfew.

Just the way things are in the community that I live and work. It's that alcoholism and drug abuse is an expected norm at about 12 years old.

Effects on Children. This category had two different themes present. First, it was common to hear personal and heartbreaking accounts of how substance abuse had affected the adult participants in this study. Personal accounts of neglect and deprivation due to parental substance abuse were typical. Some stories also portrayed histories of mild to severe physical abuse that the adults endured as children.

The second theme centered on the participants' concern for children and adolescents who were currently growing up in substance-abusing homes.

OK—boy—effects of alcohol on my family made me grow up way, way too soon. I did not have a childhood. I'm the oldest kid of three. I did not have a childhood...and drunk parents. Driving them home. It started at about 8 years old, driving home from wherever the booze was, sitting on your father's lap with one of the little sisters working the pedals, and you trying to keep the vehicle on the road to get home with everybody's lives in your hands it seemed like on a daily basis. No childhood, period.

But where substance abuse came into my life was my mom; as a child of an alcoholic. And I would watch her do all these nutty things that didn't make sense to me, and I thought she was—

sometimes I thought she was stupid, and sometimes I thought she was weird. I can remember watching her lie to my dad over the most inconsequential thing when I was 10 years old. I was watching them go back and forth, and back and forth, and back and forth. It wasn't until I found out what adult children of alcoholics act like, and I thought, this is my mom.

Using Drugs. It was startling to hear the stories of drug use and abuse among the participants. Several of the participants admitted to using drugs or associating with others who use. These stories are tinged with sadness; those who use always try to get off, but relapse seems inevitable in the face of nonexistent treatment resources for Native Americans.

2. Individuals Express Their Needs.

Many of the participants expressed a concern both for their own needs and for the needs of other Native Americans. Many participants expressed the need for good treatment and aftercare that was culturally appropriate and sensitive to Native Americans. They talked about the lack of treatment in Native American communities, and some expressed anger at the scarcity of treatment and aftercare services. The other needs expressed by the participants included the need for education, to learn about Native American culture, to provide children and youth with alternative activities, to heal, and to obtain tribal involvement.

I think the government—and I'll blame them, you know—they don't want to pay for treatment for people. But look at how much it's costing them not doing it, you know, on the reservation or an urban setting like we have.

Education is the key, especially with the focus being on children of alcoholics. Education is the key because those kids are—they're innocent. They very much want to learn. Their behavior is to learn. And the more youth education from groups like NANACOA or other related organizations—you can probably get through to them a lot quicker—and partly training in abstinence types of setting for children. Maybe

they're not going to learn from it in the beginning, but they'll recognize it a little bit earlier if they use at all.

3. Blame Whites for Bringing Alcohol into Native Land.

This divergent concept was primarily found within the youth focus group. In addition to blame, several of the youths expressed their anger and frustration with experiences with alcohol and other drugs. One of the youths summed up the situation: "Columbus started it all." Another youth said, "The white man gave us booze and stuff, and that's the main cause that's killing our families."

4. Children and Youths Lack Adequate Parental Support and Guidance.

Several participants in various focus groups expressed their concern for their children's well being. They talked about how youths these days have been neglected and have not had proper parental guidance. In addition, adults expressed the need to provide activities, and that parents need to serve as positive role models so that youths do not fall into the cycle of alcoholism. Youths also stated that parental support is inadequate, and that they did not know what to do about alleviating that problem.

5. People Are Treated Differently Due to Their Color.

Several focus group participants explained that they are treated unfairly or differently because of their appearance. One participant stated the following:

People will be looking at me strange, looking at me weird, they treat me different because of my long hair or something like that. Just because you're different. It doesn't matter how much money you have, it doesn't matter how many degrees in college education you have; it doesn't matter, any of that stuff. The bottom line is if you're different, they're going to treat you different.

Other participants described how they experienced prejudice in the past due to their color and that they have come to expect a difference in treatment. Under such circumstances, par-

ticipants often feel that they are putting themselves at unnecessary risk by telling non-Native people their stories.

6. Individuals Resent the Abuse of Native Ways Through Commercialization.

Many participants, especially those in the youth focus group, expressed resentment regarding the commercialization of Native American ways. While there was no direct opposition voiced to sharing some of the knowledge of Native American ways, especially as it pertained to Native American ways that protect our planet and environment, many participants felt like they were being "ripped off" of some of their sacred knowledge. Interestingly, some of the participants felt that it was not only whites that were exploiting Native Americans, but it was also some other Native Americans who were exploiting their own culture for commercial gain.

> *Because they're abusing—like they've learned our ways. But if there's somebody out there selling vision quests—$500 for a whole vision quest, $250 for a half one—what's a half vision quest, and why are they out there selling them? I don't get it. They abuse it—like they try to learn our ways, and they just do it all wrong. And whoever is doing it is selling out.*

7. Those Who Are Aware of NANACOA, NANACOA Activities, and Posters.

Respondents who were aware of NANACOA were able to describe NANACOA's mission, the information that NANACOA provides, and the posters that NANACOA distributes each year. Tribal leaders and, in some cases, even whole communities were aware of NANACOA. Some respondents described NANACOA as an area of healing. One respondent said succinctly that NANACOA is "a network, a support, an understanding."

> *We certainly look at families, but I think that NANACOA has provided a springboard for children of alcoholics to come together and begin the healing process; to understand what*

they've inherited through their family addiction and through their heritage as Native people; to understand the healing process that's available to them.

Some respondents described NANACOA's mission as a healing process:

They link with traditions so it helps folks—it's almost like gaining permission to start looking at their own heritage and to come back to it. They involve spiritual leadership so folks have a sense of how to connect with that healing process. So they understand what they're going through as a healing process. Not as folks who are somehow damaged goods and need to get fixed, but rather that we have a very strong heritage that provides for some pretty powerful healing.

Respondents were able to describe more concretely the literature that NANACOA provides. In addition to conferences, participants talked about the workshops that NANACOA provides, the videos that NANACOA distributes, and the newsletters that it delivers. Participants described this information as beneficial to understanding what NANACOA hopes to accomplish.

Certainly, their annual conference has become quite well known. Some of their training materials are quite extensive. I mean, whole workbooks that provide professionals working with either families or communities. Provide some of the education they need to understand family dynamics, to understand delayed grief, to understand what we inherit, based on our history of oppression and genocide. Also, to provide a way out. It's very comprehensive, the training materials and networking. They provide a newsletter that keeping people informed of what's going on. I think that's what I know.

More specifically, participants talked about the NANACOA posters that are created each year and where they may be found within the community. Several posters are used for decoration as well as information—in some cases the posters are laminated before they are displayed. Focus group participants also discussed how their tribal leaders know about NANACOA. Some

tribal leaders are aware of NANACOA through their own recoveries. And most tribal leaders support the attendance of tribal members at conferences, often providing monetary assistance.

8. Those Who Do Not Know about NANACOA—They Do Not Yet Know of the Benefits NANACOA Provides.

Responses from the focus group participants regarding their knowledge of NANACOA varied along the several dimensions. Some of the participants talked about how their tribal leadership was uninformed about NANACOA. Other participants knew nothing about NANACOA, and still others had only the briefest understanding of what NANACOA was about. Several participants talked about the lack of community knowledge of NANACOA. Surprisingly, many of the individuals who are involved in the Native American treatment communities were also unaware of NANACOA.

> *At home, they may know about it. Most of them don't, though. Even if they do know about NANACOA, they don't really know what goes on at these conferences and throughout the nation because if they did, they would be here.*

9. NANACOA Is an Organization That Promotes Healing, Encourages Learning, and Serves as a Source of Support and Empowerment. NANACOA Allows and Enables Individuals to Focus Themselves.

All of the focus group and personal interview participants who knew about NANACOA clearly described NANACOA as crucial to the healing process. As a place of healing, one of the participants said, "I just know that I will not take another drink, and that's what NANACOA has done for me." Some participants also said that NANACOA helps them to take care of themselves. Participants also described NANACOA as a source of support and empowerment and as an organization that promotes learning.

> *I think it's wonderful because I've learned so much. I never even thought about the children of the alcoholics. It never dawned on me how much it affected the children.*

I think it's real important because a lot of the times Indian people need to identify specifically with themselves, and with an organization like this—being a part of an organization like this—is one of those ways available for them, versus the traditional AA meetings and stuff.

I guess that my opinion of NANACOA is that it's something that helps me to learn more about my traditions and cultures, and feel good about it, and then take that back home to share with other people.

I think [NANACOA] is very important for a lot of reasons. One would be because Native Americans need a national organization like this where they can come together and share ideas and also for the political strength that it gives to the substance abuse field and the population of Native Americans in general.

10. Individuals Need to Share What They Have Learned from NANACOA and Often Encourage Others to Take the Healing Journey.

In describing the importance of NANACOA, participants explained that NANACOA needs to be promoted throughout the Native American community. People can spread the word about NANACOA by showing the NANACOA video, sharing with staff members and family members the experience of attending NANACOA conferences, working with kids in schools, and developing a sense of responsibility to share NANACOA with the community.

I work with kids, you know, the elementaries—he works at the high school—and I can't wait to get home and share what's in my heart. Not by words, but by doing with those kids, and they feel it. They know it.

NANACOA, I think, is very important. We must, we must share this information. We must spread the news that NANACOA is here, and we must support it. If any people really believe in their children and in the future, we must do this. I've sat here

and I've listened, and I'm learning. What you're sharing with me I'm gaining knowledge. I'm young; I've still got a long way to go. I've got children who need me. Fortunately for me I have a husband who supports me, too.

11. NANACOA Activities Are Heartfelt Experiences and Encompass Indescribable Positive Feelings.

Several focus group participants and personal interviewees were only able to describe NANACOA in terms of heartfelt experiences. The heartfelt experiences and positive feelings reflect the importance of culture and some of the experiences at conferences. Supporting quotes speak for themselves about heartfelt experiences:

I never knew much before that, except the bad things—and then I went to NANACOA. I remember the first time I walked in there and there was—I don't know how many Native Americans there were in that Missoula one. That was the first time that I had been anywhere with educated and healing Native Americans. The whole, I don't know, three days or something that I was there, I had this big lump in my throat that just wouldn't go away, you know, and I think it was because of my heart. There were some real neat things happening there. I had never been to anything like it before.

To be part of an organization or a family that's about change in Indian country, about sobriety, about acceptance of where we come from. It makes my heart sing. That's the only way to say it. To end the cycle of shame and guilt and pain and say this is just where we come from. This is just what we've experienced. To see our resiliency. See what we have lived through and to share that with my children and other Indian children. To say, okay it's tough now, but look back. If you look at your lineage somewhere you're going to find a warrior, somewhere you're going to find an artist, somewhere you're going to find a medicine person that's been in your family tree. So there has been strength from the beginning of time.

12. Cultural, Spiritual, and Traditional Importance.

Throughout almost all of the personal interviews and focus groups, one of the most pervasive themes found described the importance of culture, tradition, and spiritual beliefs. Cultural traditions are passed from generation to generation, and the significance of cultural beliefs cannot be downplayed.

> *We talk about education. We talk about culture. We talk about people. But yet, what's it all about? Talk is cheap. Action speaks louder. It's true. We have to go back into the circle of life. We have to sing the songs that are asked to sing. We have to dance the dance. We have to say prayers. That is our strength. This is our strength. Our ancestors. Our chiefs. Our children—I have children—and when I look at my children I know I have to gain more information. I know I have to gain more knowledge because these are my children. Because I want what's best for them, because I know they can be the best they can be because I've done it for myself. I am my children's' role model; I am their example. Me! What happens in my home affects my children."*

Several participants also said that they were proud to be Native American—it is "rewarding" for many participants to have ethnic pride. Despite some of the difficulties of being identified as a Native American, the feelings of goodness and ethnic pride far outweigh these difficulties. One of the participants succinctly states, "I've become really glad that I'm Native American. I'm proud of who I am." Others share their culture through classes and school and projects in the community. These activities include making grass-dance outfits, teaching dances, painting drums, and putting up sweats. Cultural projects such as these raise self-esteem among Native Americans, increase pride in one's ethnicity, and help to break down the barriers of prejudice. One of the participants even described one of the culturally healthy alternatives to drinking.

> *"Well, you know how people say they drink to relieve stress, well, you know, there's different ways, like taking a sweat. Taking a sweat relieves stress....You don't need to drink. Go*

take a sweat, you know. I mean, if you want to relieve stress, you go take a sweat.

Several participants described how they felt that they were getting back in touch with their cultural traditions; it is imperative that Native Americans do not lose their cultural heritage.

Several participants also talked about the importance of Native American spirituality and cultural support in the role of treatment and recovery. One participant expressed his dismay that some tribes are attempting to downplay the cultural aspect from healing.

You know, it's really interesting, too, because there's a tribe back in eastern Montana, I'll not name the tribe, that recently withdrew all cultural support in treatment. They took out their traditional embers, they took the sweat lodges down and said that that doesn't have any place in AA or recovery treatment. I said, "Woo."

Just as important, NANACOA has played a role in many of the participants' lives for promoting Native American culture; NANACOA encourages Native Americans to follow traditional ways and, for those who feel they have lost their traditions, to help them rediscover what was once lost. NANACOA supports and promotes ethnic pride and the role of culture in healing.

I think I feel today that that spiritual effect is happening with my family because of NANACOA, and it's instilled in my grandchildren...I can't thank NANACOA enough for what they've done for my family.

I don't even know how to dance. I don't know how to sing, and I don't know how to, you know, I didn't know how to make any Native American outfits and that kind of stuff. Well, I'm learning those things now...I didn't learn them there, I learned the importance of them there and went home and thought that I'm going to learn them. I remember when I went to the Training for Trainers, they said something about, "If you can talk, you can sing. If you can walk, you can dance." I work in an elementary school, and I have a little 8-year-old girl who

is teaching me how to dance, you know, because I've never learned before, and I'm going to get out there and march... and I'm going to dance even though I've never done it before.

13. The Community, Family, and Friends Are All Components of the Healing Journey.

Participants in focus groups and personal interviews described the importance of the community in the healing process. Several participants felt that the support of the community was crucial for keeping Native Americans on a sober path: "If you don't have that support system within the community, the individuals are going to go back to their use of alcohol."

In addition, participants said that the community should be accountable for holding nondrinking functions and should have support groups because, "People don't want to go outside the groups that they don't know or whatever, and if there's not something in their own community, then people don't go."

I think it's important to encourage our communities to take action. If the council doesn't want to take action, then that's their business. We as a community have to become responsible. We as mothers, fathers, grandfathers, need to take that action if the council doesn't, because these are our children; these are our communities.

14. The Necessity of Taking Care of Oneself First Is an Important Aspect of the Healing Journey.

Some of the participants emphasized that the healing journey often needs to focus on the self. Although focusing on one's self is important, several participants stressed that they are not alone on the healing journey. NANACOA plays a role too, recognizing that some people are neglecting themselves and need to focus attention on listening to the self. The importance of spirituality was shown with this concept also.

Well, I think that the more times I see people that are willing to make a change in their lives, it gives me more reason to go out and do what I need to do for myself. Like I'm not alone.

15. Suggestions for Improving the Operations of NANACOA.

Many of the participants offered suggestions to NANACOA for improving its organization and their service delivery. These suggestions included having NANACOA open up regional or local offices, offering travel scholarships to the needy, offering more conferences and workshops, and providing local workshops and conferences.

I know that it is difficult to set up an office in every community or whatever, but make it accessible to communities across the country, if it's at all possible.

I think the more they can do for us in the Northeast, to get in here more often, even if it's a smaller kind of gathering, a workshop. Don't give up on us if there wasn't a good showing for the workshop. I think they were anticipating or hoping for 25, and I don't know, maybe got 10 people. Don't give up on us. I'm not sure if that's differently, that's assuming they have given up on us.

If I had the access to funds, I would like to bring as many people from my reservation to NANACOA because I believe that it would touch their lives.

I like your idea about being able to bring it home. You know, like in Great Falls—to have maybe not as big, but just a branch of a workshop for free, and for people who, you know, the families that can't afford it or that aren't working. An organization that would send them here because I think that not only is the need there, I think the desire's there too. They just don't have the opportunity. If I didn't work for the school where I work, I would never get to come...because on my own, I couldn't afford it.

They've done a whole lot for me, and I appreciate it. But I also want them to be more organized. In a loving way, I want to tell them that I want them to be more organized.

Recovery, yes. Recovery. Especially for teenagers. How to get teenagers into recovery at 16 and 17 so that they don't have to wait until they're well into their 20s, and they've already had 14,000 bad relationships and a million battle scars. I would like to see NANACOA create a stronger youth group and a stronger youth outreach program and start dealing with the issue of adulthood—where in Indian country we become adults at 11 and 12 years old. That's where I really feel it needs to start at, so that your kids can be empowered in that way and maybe bring their parents around.

I think at one point NANACOA was saying that they would have elders. I think at one time...there would be elders present—in the general sessions there would be elders. I thought that was very important. I think the youth need to be in there. Brought in. I think that facilitators need to be trained and improved and aware because things are moving fast, happening fast. I guess I just I want people to know about NANACOA. I want people to belong, to say, well, I can go there. Because no matter how old I am—I think everyone needs to learn. We can all learn.

16. Individuals Who Help May Need Help Themselves.

Many of the participants felt that some of the treatment community needed treatment themselves. Several participants felt that the helping community could use some help for their own substance-abuse related problems. In some cases, the participants felt that some members of the treatment community did more harm than good, and that some type of credentialing or monitoring system should be in place that was both sensitive to Native American culture and the foundations of safe and useful treatment.

17. Youth Experience Problems and Express Attitudes Not Expressed by Other Groups.

These divergent concepts were mostly found within the youth focus group. One of the youths said that self-expression is

important, "Nowadays, I'm expressing myself more, you know, talking to my cousins all the time, telling them how I feel. If they laugh at me, well, you know, I'll flip them off and tell them to go somewhere else, you know, you aren't my real cousin." Some of the youths expressed how they felt they had worse problems than adults did, yet adults were the main focus at many conference workshops. Another youth talked about how all of his role models are historical and are no longer alive and that no one will be able to fight for "our" rights. He expressed his concern that there are no longer any living role models. Another youth talked about how he respected his elders and that people need to listen to the elders' stories. However, he agreed with the previous youth that many of the workshops are "based around adults."

> *It was like, I think, it was one of those youth and elders conferences, but all they talked about was the elders and helping the adults and all that stuff, you know. I mean, not really focusing on the children because they probably think the children don't have any problems. We're the ones who have worse problems than...them. We can't even walk down the road nowadays without someone yelling [inaudible], you know, pointing guns at us and stuff like that.*

18. Native Americans Need to Help Native Americans.

Several focus group participants and many of the personal interviewees expressed the necessity of having Native Americans helping Native Americans. Only Native Americans know of Native ways and "Indian methods." NANACOA needs to be mostly run by Native Americans.

> *It's essential for Indian people. You have to have Indian ways. You have to have an understanding of Indian people in Indian communities. You have to have Indian methods. You have to have, I believe, Indian people involved in it, the community involved in it. As far as I can see with all my experience at this point, there's no way to make any change in a positive way without it being Indian in every aspect.*

Discussion

The largest group of correspondents was individuals who requested information about children of alcoholics. The letters from these individuals frequently contained personal information about how the person had been affected by alcohol. They were grateful that NANACOA existed. From 1991 to 1994, letters and requests for information from nontribal and non-Native correspondents increased from 65 percent to 74 percent. This could be a reflection of NANACOA's outreach to non-Native communities, or of the growing interest and concerns of non-Natives about Native American issues.

There seemed to be no seasonal variation in requesting information. Not surprisingly, during the 4-year span, the two most frequent requests were for newsletters and to be added to the mailing list. While there was no discernible pattern of requests by geographic region across time, it was evident that when the NANACOA conference was in a particular region, requests from that region increased.

The majority of preregistrants for the annual conferences were either American Indian or Alaska Native. Almost half of the preregistrants claimed tribal or Native employment. During the 3-year period, the proportion of male to female attendees remained fairly constant. The number of conference attendees from a certain region increased when the conference was held in that region.

Personal Interviews and Focus Groups

The findings from the focus groups and personal interviews were rich in history and detail. Participants' stories were as varied in description as the individuals themselves, yet several common themes were identified. One powerful theme traced the negative effects of substance abuse in the participants' communities, in the lives of the participants, and in the lives of those they love. Each participant had a personal history to relate, whether it was their own or that of a family member. The participants emphasized the negative effects of substance abuse.

Many participants were adult children of alcoholics who were raised in families riddled by the economic and emotional problems caused by substance abuse. Many of the participants mentioned the generational transmission of substance-abusing behavior: alcoholism passed down from parent to child. They also said that they were familiar with the destruction that substance use and abuse had caused with their families and friends. Substance abuse was common in the community, and substance abuse was linked to family breakups, physical and emotional abuse, violence, financial problems, and other community problems. Participants stated that alcohol and other drug-taking behavior negatively affects the Native American community and participates in the destruction of culture. In addition, alcohol and drug abuse contributes to the loss of self.

Participants expressed their concerns about the affect substance abuse has on Native American children. Heartbreaking accounts of how substance abuse had affected children were common. Personal accounts of neglect and deprivation due to parental substance abuse were also typical. Some of the participants' voices portrayed experiences of mild to severe physical abuse endured as a child because of alcohol. Another concern expressed by the participants was that a second generation now had to endure what the participants themselves had to endure as a child. The participants wanted this generational cycle of substance abuse to stop and felt that NANACOA was instrumental in this endeavor.

While many voices spoke about the negative and overwhelming effects of substance abuse on the Native American family and community, these same voices spoke of the strength and influence of Native American traditions in overcoming these negative effects. The importance of culture, spirituality, and tradition was a theme that was mentioned in almost every focus group and personal interview. Most participants said that learning about Native American traditions would help counteract the negative effects of substance abuse. The participants recognized that Native American culture, tradition, and spirituality protects individuals from substance abuse and guides

individuals toward a healthy path. In the words of one participant:

> *I can't be worried about whether I'm doing something or following—I mean I'm in the process of learning. Whether it's my traditions or the protocol or certain events or how to do a certain kind of ritual or healing kind of thing...I have to go for the spiritual part, I have to remember what's in my heart and that if I'm involved in a circle and the circle's going in the wrong direction, it doesn't mean I have to run away in shame because I did something wrong, but that I can listen to those who are willing to teach me and learn the correct way to do something.*

The participants stated that culture is important and that NANACOA realizes culture is important too. NANACOA promotes learning, healing, and spiritual growth. The cultural traditions passed from generation to generation are seen as protective factors against the growing problems associated with alcohol and drug abuse. Despite the difficulty of living in a prejudiced society, many participants suggested that knowing about their culture helped them maintain a sense of pride about their ethnic heritage. Several participants said that they experience their culture through classes and community activities. These activities included making grass-dance outfits, teaching dances, painting drums, and putting up sweats. Cultural projects such as these raise self-esteem among Native Americans, increase pride in one's ethnicity, and help to break down the barriers of prejudice. Many stated that it was imperative that Native Americans maintain close contact with their cultural heritage, not only to maintain a sense of ethnic pride, but also to endorse Native American spirituality and culture in the healing process. NANACOA upholds this premise by encouraging pride in one's ethnic identity, stressing the importance of rediscovering Native American ways, and affirming the importance of culture in the healing journey.

Some of the participants emphasized that the healing journey often needs to focus on the individual. Although focusing on the self is important, several stressed that they are not alone on the healing journey. The community, family, and friends are

seen as components of the healing journey. Several participants stated that the support of the community was crucial for keeping Native Americans on a sober path. Participants also stressed the importance of family, friends, and staff members in maintaining a sober lifestyle.

The participants who knew about NANACOA said that NANACOA was important to both individuals and communities. They described NANACOA as an organization that promoted healing, encouraged learning, and served as a source of support and empowerment. According to these participants, NANACOA enables individuals to focus on healing and recovery. Participants stated that NANACOA plays a role in helping individuals recognize that they sometimes neglect themselves. NANACOA teaches individuals what they need to know about self-care.

The focus group and personal interview participants defined the transactional relationship that NANACOA cultivates: what NANACOA gives to the individual, the individual gives to the community, and the community in turn gives back to the individual. When members spread the word about NANACOA through videos, posters, or conference messages, they spread the word of care. Several participants described how NANACOA activities are heartfelt experiences and encompass indescribably positive feelings. Participants described how their experiences were powerful enough to change their lives. As one participant said, "I can't say why I've learned, because it's mostly in the heart, but I know that when I got home it was like, you know, excitement. It kind of made me emotional. This organization does that to me. I don't know what it is."

Finally, the recommendations to NANACOA made by the focus group and personal interview were thoughtful considerations of how NANACOA could better serve Native Americans. Some of the recommendations centered on money. Many of the participants stressed the need to have more affordable conferences and workshops. Many of the suggestions were about how to improve programs and outreach. Suggestions about outreach centered on four main areas. First, participants suggested that the programs should be multigenerational. Participants wanted

to include elders in the conference programming and many saw the need to have a separate youth track. Second, the participants wanted NANACOA to come to the reservation, because, as one participant noted, "you never see anyone really try to reach a reservation like they try to reach the bigger cities or inner cities." Third, participants wanted NANACOA to come to the smaller communities, especially in the Midwest. Lastly, participants asked for regional representation. While many participants expressed that NANACOA as a national organization is useful, they also want NANACOA to have regional representation.

Data Limitations

The data reported in this study have some obvious limitations. First, the archival data is biased due to sampling procedures. The data used in this evaluation included conference preregistrants only; conference attendees who registered on-site did not complete a registration form. Therefore, on-site registrants were not included in this analysis. Also, data were missing due to yearly changes in the preregistration form. Information on gender, ethnicity, employment, job, state, and method of payment was available for 1992 through 1994, but age and education data were available for 1992 only. Although every attempt was made to gather all of the correspondence for the years 1991 through 1994, it is likely that some of the correspondence was unaccounted for.

One of the limitations of the focus group and personal interview data was that the focus group and personal interview protocols were not always followed. In some cases, the facilitator did not ask questions listed in the protocol. Additionally, most of the facilitators did not complete the evaluation form that asked about characteristics of the participants, such as their age, gender, and the number of participants in the focus group. Thus, the number of participants in each focus group along with other important information was not noted. Another limitation occurred during the transcription of the audiotapes. Some of the tapes were inaudible in parts, and other tapes were completely inaudible.

Another limitation of the evaluation was the small number of participants in the focus groups and personal interviews. Although the evaluation was national in scope and included participants from New York, North and South Dakota, Arizona, Montana, Washington, Minnesota, Oklahoma, California, South Carolina, Oregon, Maine, Florida, Kansas, Alaska, Idaho, New Mexico, and Utah, the number of Native Americans who participated in the evaluation did not represent the entire Native American population. Not all tribes were represented. Therefore, it would be inappropriate and inadvisable to generalize these results to all tribal communities and Native Americans. Nevertheless, the voices of those who participated must be heard. The Native Americans who participated in this evaluation resounded the concerns and needs of a population that wants to heal. The meaningful experiences of many Native Americans were shared and their voices must not be silenced or ignored.

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7

Do School-Based Drug and Alcohol Abuse Prevention Programs Work in American Indian Communities?

Fred Beauvais

Abstract

School-based drug abuse prevention programs have been a standard approach in American Indian communities over the past three decades. However, there is very little evidence these programs have been effective. In addition, on theoretical grounds, schools are not in the strongest position to counter drug use among adolescents. As compared with non-Indian families, American Indian families have been shown to have a more powerful influence in the lives of their children. Therefore, for these initiatives to be effective, it is very clear that anti-drug abuse programs must enlist the help and support of American Indian families.

While it is common to ask such broad and important questions as posed by this chapter's title, most researchers and practition-

ers realize that, given the complexity of substance abuse behavior, simple answers will not be forthcoming. Even such thorough and thoughtful reviews of drug abuse prevention strategies among American Indians as provided by May (1995) and May and Moran (1995) lead to more questions than to straightforward answers. A study of May and Moran's work, as well as that of Owan, Palmer, and Quitana (1987), The Office for Substance Abuse Prevention (Breaking New Ground, 1990), and Hayne (1993, 1994), provides a comprehensive picture of drug prevention efforts in American Indian communities. That work, therefore, will not be restated here. Rather, it is the purpose of this chapter to focus on school-based prevention efforts in American Indian schools, to ask some hard questions about the assumptions underlying these efforts, and to determine whether the energy that has been expended in this regard is warranted.

The introductory chapter to this volume contains a summary of the trends and patterns of substance use for American Indian adolescents. Basically there have been consistent findings of higher levels of use for American Indian youth, but the pattern of increases and decreases over the past two decades have been similar for both American Indian and non-Indian youth (Beauvais, 1996). The most recent evidence points to increases in drug use since 1992, with a possible recent leveling off (Johnston et al., 1998; Beauvais, 1996). For some time there has been a strong recognition of the nature of the substance abuse problem in American Indian communities, and a significant amount of effort has gone into prevention of these problems. Unfortunately, too few of the programs that have been implemented are based on theory and even fewer have been evaluated in any thorough manner.

The question of the efficacy of school-based programs specifically is not an insignificant one, since the reviews cited indicate that school-based prevention efforts are by far the most popular approach in American Indian communities. In 1987, for instance, Owan, Palmer, and Quintana identified 420 school drug-prevention programs in American Indian schools; this was a low estimate since many schools did not respond to the survey used in this study. In one sense schools are a convenient venue

for conducting prevention programs, since they are places where there is easy access to young people. Further, there is this legacy within the prevention field: that if only young people could be educated as to the negative effects of drugs, their substance abuse would subside. Hence, schools would seem to be the logical place to impart this information. This view may be misguided, however, and it would be useful to question it on theoretical grounds.

The breadth and combination of those social factors affecting the trends in adolescent drug use remain elusive, and in the absence of certain knowledge there will be a lot of *post hoc* explanations for the increases and decreases in use that have been observed over time. Rather than speculate, it would be helpful to turn to theory as a guide in understanding the changing patterns in adolescent drug use. Oetting (1992) has proposed one way of looking at the determinants of adolescent behavior. There are three major socialization forces that influence the behavior of youth: family, peers, and school. By examining these forces and the links between them, we may gain some insight into why adolescents, over time, act differently with respect to drugs. It should be kept in mind that any speculation should be tentative and that final judgment must await objective verification.

Family

If drug use is different now than it was a few years ago, it is likely attributable to changes in the way families respond to drugs. In the late 1970s, when drug use was rapidly increasing, families were unprepared to address the issue. Society was emerging from a time of intense youth activism, and the new drug-using lifestyles of young people came up against a family structure that had few guidelines for responding to drug use among their children. For a period of time, families were confused and immobilized. As the negative effects of drugs became more evident, families became clearer about what behaviors they were willing to tolerate and began taking action against their children's sub-

stance abuse. The early 1980s witnessed the burgeoning of the family anti-drug movement both across the United States and within American Indian communities. In that period of time, we saw the formation of thousands of parent groups whose mission was to protect their children from the consequences of drug use. Notably, as these parent groups gained momentum drug use began to decrease. The specific activities that these parent groups engaged in were probably not as important as the overall message that these groups sent to the youth. Essentially the parent movement was making it very clear that drug use was not acceptable. As drug use began to decline throughout the 1980s, the parent movement lost its potency and there was likely a perception that the problem was going away. Responsibility for drug prevention shifted to established organizations such as the schools or law enforcement (e.g., DARE) and much of the influence of the parents may have been lost. When this shift occurred, drug use began to rise once more.

Peers

The influence of peers has been well documented in the drug abuse literature as being the most powerful determinant of drug use (Oetting and Beauvais, 1986; Duncan, Tildesley, Duncan, and Hops, 1995; Clapper, Martin, and Clifford, 1994). In conjunction with their closest friends, adolescents do a great deal of "norming" around the topic of drug use, and it is within these peer clusters that the decisions on drug use are made. Given the change in drug use over the past few years, there most certainly has to have been a change in the peer environment that now makes the substance abuse more acceptable among young people.

Adolescence is a tense period during which young people are separating from their parents and becoming more responsive to socializing influences outside of the family. During this time young people will alternate between allegiance to family values and those of their closest friends. With respect to drugs, if parents have become less vocal or certain about their values, it is likely that young people will become more responsive to the

values in their peer environment—and all too often these values include the use of mind-altering chemicals.

Peers influence one another in two specific ways: they encourage one another to engage in particular behaviors, or they apply sanctions against certain behaviors (Oetting and Beauvais, 1986). Given the strong link between peers and drug use and the recent increases in drug use, it is likely that peers are now encouraging one another toward more drug use, and they are less likely to try to stop their friends from using drugs. Effective prevention programs must find ways of intervening in these developmental processes. Given the discussion of the family influence above, it would seem to be an efficacious strategy to strengthen the anti-drug messages coming from the family to offset the opposite ones coming from peers.

One of the specific messages that is shared and shaped within the peer network is the level of risk that young people perceive as accompanying substance abuse. Johnston and his colleagues at the University of Michigan have recorded a remarkable correspondence between perceived risk from substance abuse and actual substance abuse (1998). As the perceived risk of harm increases, drug use decreases; conversely, during periods when perceived risk diminishes, drug use increases. (Interestingly, availability of drugs, over time, bears little relationship to rates of drug use.) There is some uncertainty about the causative direction in this relationship: does the perception of lower risk lead to higher drug use, or does perception of drug risk go down when one begins using a drug? In one sense the causal direction is unimportant. What is important is that during times of high drug use, young people, especially those who are just beginning to contemplate use, are exposed to an attitudinal environment that downplays the risk of using drugs. During times of rising use, prevention programs must recognize these attitudes and design interventions to counter them. These efforts must be tempered, however, by the knowledge that overstating the harmful effects of drug use has been shown to be ineffective in reducing use. Further, just providing information about drugs without other prevention strategies has not been an effective strategy.

School

The third important socializing influence in the lives of young people is their school environment. Young people spend a great deal of time in school and thus are subject to the values of that system. This system has become even more central in the lives of children in recent years as the schools have been asked to assume greater responsibility in areas formerly reserved for the family such as drug prevention, sex education, health, and family planning.

Given that drug prevention efforts in the schools are so widespread, it is reasonable to ask how effective these are and whether the results are worth such a major investment. In reading the materials available on school programs in American Indian communities, one is hard pressed to find much evidence that these programs are effective in the long term in reducing drug abuse among American Indian youth (Owan, Palmer, and Quitana, 1987; Breaking New Ground, 1990; Hayne, 1993, 1994). This is not to say that these programs are of no value, since they may have other positive effects on youth and serve as one method of communicating society's values regarding substance abuse.

The relative lack of effectiveness of school-based programs is not limited to American Indian communities. Two recent sources document this. Gorman (1996) reviewed the results of school programs: those that were only informative and those that focused on affective approaches (e.g., decision-making skills, stress management). This study concluded that both of these types of programs were largely ineffective in reducing drug use. Gorman then analyzed the results of 12 recent large programs that were based on developing social and refusal skills, and came to much the same conclusion. Some short-term changes in attitudes about drugs and drug use were noted with some programs, but these changes were not sustained over time.

Botvin et al. (1995) have also reviewed the literature and concluded "...sound, empirical evidence for the effectiveness of

school-based interventions on these drugs [alcohol and marijuana] is limited (p. 1106)." This study then goes on to report on a newly developed school-based intervention, and the study does produce evidence for this program's effectiveness. More important than the actual content of this new program, however, are the conditions that the program sets out for any school-based intervention to be effective.

First, the program has to be potent enough to actually have an effect on the complex, and perhaps long-standing, behavior of drug use. Most programs are very limited in the amount of time that youth are involved in them, and thus it is unreasonable to assume that drug-using behavior in youth can be impacted by the short duration of most interventions. For example, a 10-session program over a 10-week period certainly cannot be expected to make a lasting difference.

Second, effective programs need booster sessions that are given at sufficient intervals to reinforce the changes resulting from the program; one-shot programs cannot lead to lasting changes.

The third element of a successful program is making certain that it is implemented in its entirety as it was designed. All too often, prevention workers take only certain parts of effective programs and apply them in the classroom; this often destroys the efficacy of a successful intervention. Along with complete implementation, it is important to make sure that the people running the program are doing it consistently and completely. Botvin and his group found that interventions were more effective when the programs were monitored and the trainers were periodically given extra training and support.

Finally, many programs in the past have been based on ineffective principles and simply do not address the issues that will lead to reduced drug use. Gorman, cited above, found very clear evidence that education based solely on the effects of drugs or on improving affective functioning (e.g., improving self-esteem), do very little in the way of countering drug use.

All in all, it appears that school-based prevention programs have not been demonstrated to be very effective, and to be effective they have to adhere to fairly strict guidelines. It is not likely

that these guidelines are followed in most instances, including with programs in schools serving American Indian youth. One common reason for this is that, as Botvin et al. noted, effective school-based prevention programs take a tremendous amount of school time and require extensive training and monitoring. Many schools find that it very difficult to provide even basic academic instruction and cannot afford the resources for addressing behavioral health issues.

Another major reason why drug prevention programs in the classroom may not be very effective is that most drug use does not take place in the school environment. Beauvais (1992) reveals that the majority of drug and alcohol use occurs outside of the school context, with most of it taking place on weekends, at night with friends, and in the home. Should drug use in these circumstances be the responsibility of the schools? Clearly this is a larger community issue, and it is unreasonable to assume that schools alone can address it.

Should School Prevention Programs Be Eliminated?

Probably not. In May's (1995) thorough review of alcohol prevention activities in American Indian communities, he concluded that the lack of effectiveness was due to the incomplete nature of prevention efforts. He recognizes the complexity of drug abuse and strongly recommends that comprehensive, community-wide action is needed. For some time, the schools have been taking their part of the burden, but this has not been matched by other elements of the community, where most drug use takes place. School-based efforts have simply not been, nor can they be, sufficiently potent to counter the problem. Rather than eliminating these activities they should be maintained and strengthened, as recommended by the Botvin et al. study. However, it is essential that the rest of the community join in so that a powerful and unanimous message is sent to young people regarding substance and alcohol abuse.

The Strength of American Indian Families

American Indian communities have a potential advantage for attacking the drug abuse problem. It is widely held that American Indian families play a greater role in the lives of their children and that this influence continues further into the adolescent years than it does among non-Indian families. This has certainly been demonstrated for family influence on drug use in a recent research project (Swaim, Oetting, Jumper-Thurman, Beauvais, and Edwards, 1993). Pathways to drug use for both American Indian and non-Indian youth show similar factors influencing drug use for the two groups, with some significant exceptions. For the American Indian youth, the strength of the link between peers and drug use is much lower, indicating that the peer process is not quite as important for them. More importantly, there is a direct link apparent among American Indian youth between family sanctions and drug use; apparently American Indian youth are more responsive to their parent's negative attitudes toward drugs than are white youth. Finally, white youth who make a better adjustment to school seem to have lower rates of drug use, whereas there is no relationship between school adjustment and drug use among American Indian youth. This latter finding is not surprising, since school is less important in the lives of American Indian youth (LaFromboise and Low, 1989); adjustment to school, therefore, would not necessarily be as strong a protective factor against using drugs.

Conclusion

The question posed in the title of this article is not an easy one to answer. The evidence for the effectiveness of school-based drug prevention programs is fairly meager. However, it is unreasonable to expect that the schools alone could have a major impact on a behavior that has multiple and interactive

social causes. At the same time, it would be folly to eliminate these school-based efforts since they are coming from one of the major socialization forces in the lives of American Indian children and it may be that these initiatives are having some as-yet unmeasured effect. The total answer to the drug abuse problem will only come when all of the elements of the community can come together and present a unified message to their young people. May (1995) has listed the many specific avenues for prevention that are available in American Indian communities and concludes that all of these must be brought to bear on the problem. Given what we know about American Indian families, and what the research is beginning to show, it is absolutely essential that they be significantly involved in any drug prevention strategy. Any effort that does not include the family will certainly be overlooking the major asset of American Indian communities and likely will not succeed. The schools continue to do their part, but they alone do not have the potency needed to address this most serious problem.

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